NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

PREAMBLE

1. Sections Affected / **Rulemaking Action**

Sections Affected	Rulemaking Action
R4-26-101	Amend
R4-26-102	Amend
R4-26-103	Amend
R4-26-104	Amend
R4-26-105	Amend
R4-26-106	Amend
R4-26-107	Amend
R4-26-108	Renumber
R4-26-201	Renumber
R4-26-201	Amend
R4-26-202	Amend
R4-26-203	Amend
R4-26-204	Amend
R4-26-205	Amend
R4-26-207	Amend
R4-26-208	Amend
Table 1	New Table
R4-26-209	Amend
R4-26-210	Amend
R4-26-211	Amend
R4-26-303	Amend
R4-26-308	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. § 32-2063(A)(9)

Implementing statutes: A.R.S. §§ 32-2063(A)(2),(3), and (8), 32-2064(B), 32-2066(B), 32-2071, 32-2071.01, 32-2072, 32-2073, 32-2074, 32-2075, 32-2076, 32-2081, 32-2084, 32-2085, and 41-1073

3. The effective date of the rules:

August 7, 2000

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 714, February 18, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 1110, March 31, 2000

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

Name: Maxine McCarthy, Executive Director

Address: Board of Psychologist Examiners
1400 West Washington, Room 235
Phoenix, Arizona 85007

Telephone: (602) 542-8162

Fax: (602) 542-8279

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

The Board initiated the proposed rulemaking as a result of the Board's 5-year rule review approved by the Governor's Regulatory Review Council on April 6, 1999. The proposed rules remove the numbering in Section R4-25-101, Definitions. The definitions will be kept in alphabetical order which will make future amendments less complicated. The proposed rules also add new definitions for "additional examination" and "directly available" and amend other definitions for clarity, conciseness, and understandability. The proposed rules amend retention requirements for client records, list the requirements for applications for a psychologist's license, clarify examination, renewal, and continuing education requirements, and make numerous grammar, format, and punctuation changes to provide a clear, concise, and understandable document.

The Board believes that making these rules will benefit the public health and safety by establishing clear and understandable standards governing the practice of psychology.

7. A reference to any study that the agency relied on in its evaluation of or justification for the 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

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

Not applicable

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

The Board will incur minimal costs in writing and publishing the rules, notifying interested parties of the new rules after approval, and complying with license time-frames. License applicants and the Board will benefit from increased consistency and efficiency in the licensure process. There are no expected costs for other government entities, psychologists, or the public.

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

A few minor changes were made at the request of GRRC staff. Instead of repealing R4-26-108, we are renumbering it to R4-26-201 and instead of repealing R4-26-201, we are amending the rule. R4-26-106(E) is deleted and subsection (F) is renumbered to (E). The word "before" is used in 3 places instead of the words "prior to". In Section R4-26-204(A)(3), the last sentence dealing with a waiver is removed because it is too vague. We have decided not to amend R4-26-206. In Section R4-26-207(B)(1)(b)(i), the citation for the definition of "practice of psychology" reads A.R.S. § 32-2061(8) which is incorrect. The correct citation is A.R.S. § 32-2061(A)(8) and is changed in the final rules. Numerous punctuation, grammar, style, and format changes were made to provide a clear, concise, and understandable document.

11. A summary of the principal comments and the agency response to them:

None

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

Not applicable

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

None

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

No

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

ARTICLE 1. GENERAL PROVISIONS

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R4-26-101. Definitions
R4-26-102. Board ~~Meetings~~ Officers
R4-26-103. Official Signatures
R4-26-104. Advisory ~~Committee~~ Committees
R4-26-105. ~~Confidentiality of~~ Board Records
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ARTICLE 2. LICENSURE

Sections
~~R4-26-108.~~ R4-26-201. Application Deadline
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R4-26-303. Titles
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ARTICLE 1. GENERAL PROVISIONS

R4-26-101. Definitions

In this Chapter~~, the following terms mean~~:

“Additional examination” means an examination administered by the Board to determine the competency of an applicant and may include questions about the applicant’s knowledge and application of Arizona law, the practice of psychology, ethical conduct, and psychological assessment and treatment practices.

~~1.~~ “Administrative completeness review” means the Board’s process for determining that an applicant has provided all of the information and documents required by the Board ~~statute or this Chapter~~ to determine whether to grant a license to the applicant.

~~2.~~ “Advertising” means the use of any communications media ~~whether paid or unpaid by a psychologist,~~ to disseminate information regarding the qualifications of ~~the~~ a psychologist or to solicit clients for psychological services, whether or not the psychologist pays for the dissemination of the information. Methods of advertising include a published statement or announcement, directory listing, business card, personal resume, brochure, or any electronic communication conveying professional qualifications or promoting the use of the psychologist’s professional services.

~~3.~~ “Applicant” means an individual requesting licensure, renewal, or approval from the Board.

~~6.~~ “Application packet” means the forms and documents the Board requires an applicant to submit ~~or be submitted on an applicant’s behalf~~ to the Board.

~~5.~~ “Case”, in the context of ~~R4-26-106(E)~~ R4-26-106(D), means a legal cause of action instituted before an administrative or judicial court.

~~6.~~ “Case conference” means ~~an informal~~ a meeting ~~among psychologists~~ that includes the discussion of a particular client~~,~~ or case~~, or diagnosis~~ that is related to the practice of psychology.

~~7.~~ “Client record” means~~, in addition to~~ “adequate records” as defined in A.R.S. § 32-2061(A)(2), ~~any assessment, plan of intervention, consultation, hand-written note, summary report, testing report, relevant supporting data, or a release form obtained from a client or third party~~ “medical records” as defined in A.R.S. § 12-2291(4), and all records pertaining to ~~the~~ assessment, evaluation, consultation, intervention, treatment, or the provision of psychological services in any form or by any medium.

~~8.~~ “Confidential record” means:

~~a.~~ Minutes of an executive session of the Board;

~~b.~~ A record that is classified as confidential by a law or rule applicable to the Board;

~~c.~~ An applicant’s or licensee’s college or university transcript if requested by a person other than the applicant or licensee;

~~d.~~ All materials relating to an investigation by the Board, including a complaint, response, client record, witness statement, investigative report, or any other information relating to a client’s diagnosis, treatment, or personal or family life. The Board shall disclose ~~if~~ whether an investigation is being undertaken and the general nature of the investigation;

~~e.~~ Home address and home telephone number of an applicant or a licensee;

~~f.~~ Test scores; and

~~g.~~ Social security ~~number~~ numbers.

~~9.~~ “Days” means calendar days.

~~10.~~ "Diplomate" means a status bestowed on a person by the American Board of Professional Psychology after successful completion of the work and examinations required.
"Directly available", in the context of A.R.S. § 32-2071(D)(2), means immediately available in person, by telephone, or by electronic transmission.
~~11.~~ "Dissertation" means a document prepared as part of a graduate doctoral program that includes, at a minimum, separate sections that:
   ~~a.~~ Review the literature on the psychology topic being investigated, state each research question under investigation, and state each hypothesis investigated;
   ~~b.~~ Describe the method or procedure used to investigate each research question or each hypothesis;
   ~~c.~~ Describe and summarize the findings and results of the investigation;
   ~~d.~~ Discuss the findings and compare them to the relevant literature presented in the literature review section; and
   ~~e.~~ List the references used in the various sections of the dissertation. A majority of the references used in the dissertation shall either be listed in the American Psychological Association's journal, Psychological Abstracts, or classified as a psychology subject by the Library of Congress.
~~12.~~ "Fellow" means a rank or position bestowed on a person by a psychology association or society.
~~13.~~ "Gross negligence" means a psychologist's breach of duty to know or have reason to know of facts that would lead a reasonable psychologist to realize that the psychologist's act or failure to act creates an unreasonable risk of harm and involves a high degree of probability that substantial harm may result.
~~14.~~ "Internship training program" means the supervised professional experience required in A.R.S. § 32-2071(D).
~~15.~~ "National examination" means the national written examination provided by the Association of State and Provincial Psychology Boards.
~~16.~~ "Party" means the Board, an applicant, ~~or~~ a licensee, or the State.
~~17.~~ "Primarily psychological", in the context of A.R.S. § 32-2071(A)(6), means subject matter that covers the practice of psychology as defined in A.R.S. § 32-2061(A)(8).
~~18.~~ "Psychometric testing" means measuring cognitive and emotional processes and learning.
~~19.~~ "Raw test data" means information collected during a psychologist's assessment and evaluation.
~~20.~~ "Residency" means the same as in A.R.S. § 32-2071(H), except domicile or hospital residency.
~~21.~~ "Retired", as used in A.R.S. § 32-2073(E), means a psychologist has permanently stopped practicing psychology, as defined in A.R.S. § 32-2061(A)(8).
~~22.~~ "Substantive review" means the Board's process for determining ~~if~~ whether an applicant meets the requirements of A.R.S. § 32-2071 through § 32-2076 and this Chapter.
~~23.~~ "Successfully completing", in A.R.S. § 32-2071(A)(4), means receiving a passing grade in a course from a school or institution.
~~24.~~ "Supervise" means to control, oversee, and review the activities of an employee, intern, ~~or~~ trainee, or resident who provides psychological services.
~~25.~~ "Supervisor" means a psychologist licensed or certified as a psychologist in the state in which the supervision occurs.
~~26.~~ "Three or more graduate semester hours" means 3 16-week semester hours, 4 12-week quarter hours, or 5.33 9-week trimester hours.

R4-26-102. Board ~~Meetings~~ Officers

~~Pursuant to~~ Under A.R.S. § 32-2063(A)(8), the Board shall meet ~~prior to July 1~~ before December 31 of each year to elect a ~~chairman~~ chairperson, a vice ~~chairman~~ chairperson, and a secretary who shall take office on ~~July 1~~ January 1 of ~~that~~ the next year and serve until ~~June 30~~ December 31 of ~~the following~~ that year. When a vacancy ~~occurring~~ occurs in the office of ~~chairman~~ chairperson, vice ~~chairman~~ chairperson, or secretary, the Board shall ~~be filled by a Board election~~ elect a replacement officer at the next scheduled Board meeting.

R4-26-103. Official Signatures

The ~~chairman~~ chairperson, vice ~~chairman~~ chairperson, or secretary, elected ~~pursuant to~~ under A.R.S. § 32-2063(A)(8), shall sign correspondence, forms, legal documents, or other official papers of the Board. The ~~chairman~~ chairperson, vice ~~chairman~~ chairperson, or secretary may delegate this duty to another Board member, or the executive director.

R4-26-104. Advisory ~~Committee~~ Committees

The Board may appoint advisory committees for the purpose of conducting investigations and making recommendations to the Board concerning official actions to be taken or considered by the Board regarding the licensing process or disciplinary matters.

R4-26-105. ~~Confidentiality of~~ Board Records

A. ~~All records which are open to public inspection shall be viewed at the Board office during business hours which are~~ A person may view public records in the Board office only during business hours Monday through Friday from 8 a.m. to 5 p.m., excluding holidays.

B. All Board records are open to public inspection and copying except ~~those that are~~ confidential~~, as follows:~~ records as defined in R4-26-101.

~~1. Minutes of executive sessions.~~

~~2. Records which are classified as confidential by laws or rules applicable to the Board.~~

~~3. College or university transcripts of applicants for licensure or of persons licensed as psychologists, except that the person on whom the file is kept may view or copy such records.~~

~~4. All materials relating to an ongoing or concluded investigation by the Board, including the complaint, response, patient records, witness statements, investigative reports, or any other information relating to the client's diagnosis, treatment, personal or family life; however, the public may be informed that an investigation is being undertaken and of the general nature of the investigation.~~

R4-26-106. Client Records

~~**A.** Pursuant to A.R.S. § 32-2061(13)(s), a client has a right to information in the client's record.~~

~~B~~A. A psychologist shall not ~~require payment for the psychological services which led to the creation of a client's record as a prerequisite to providing such material~~ condition record release on a client's or 3rd party's payment for services.

~~C~~B. A psychologist shall release, with a client's written consent, the client's raw test data or psychometric testing materials ~~may be released, with the client's written consent,~~ to another licensed psychologist. ~~Any other disclosure of~~ Without a client's consent, a psychologist shall release a client's raw test data or psychometric testing materials ~~shall only be made~~ only to the extent required by federal or ~~state~~ Arizona law or court order compelling production.

~~D~~C. ~~All~~ A psychologist shall retain all client records, including records of a client who ~~has~~ died, ~~while under the care and treatment of the psychologist, shall be retained~~ for a minimum of ~~seven~~ 7 years from the date of the last client activity, except copies of audio or video tapes created primarily for training or supervisory purposes. If a client is a minor, the psychologist shall retain all client records for a minimum of 3 years past the client's 18th birthday or 7 years from the date of the last client activity, whichever is longer.

D. A psychologist who has been notified by the Board or municipal, state, or federal officials of an investigation or pending case ~~by the Board or municipal, state, or federal officials~~ shall retain all records relating to that investigation or case until the psychologist has received written notification that the investigation ~~has been~~ is completed or that the case ~~has been~~ is closed. ~~A psychologist who is on inactive status pursuant to A.R.S. § 32-2073(E) is not exempt from this rule.~~

E. A psychologist who is on inactive status under A.R.S. § 32-2073(E) is not exempt from this rule.

R4-26-107. Current Address

A psychologist's failure to receive a renewal notice or other mail ~~which~~ that the Board sends to the most recent address ~~which the psychologist has placed~~ on file with the Board office is not justification for an untimely license renewal or the omission of any other action required by the psychologist.

ARTICLE 2. LICENSURE

~~R4-26-108.~~ R4-26-201. Application Deadline

A license application and all related supporting materials and documentation, including reference forms mailed from the Board office and any additional information requested by the Board, shall be completed and filed at the Board office at least 60 days ~~prior to~~ before the date of the next scheduled written examination. An applicant who does not meet this deadline shall not sit for that examination.

R4-26-202. Doctorate

A. The Board shall apply the following criteria ~~apply~~ to determine ~~whether an applicant has received a doctorate based on~~ if a doctoral program ~~of studies, as required by~~ complies with A.R.S. § 32-2071~~.~~:

1. ~~To determine whether a~~ A program is "identified and labeled as a psychology program" ~~pursuant to~~ under A.R.S. § 32-2071(A)(2), ~~the Board shall determine whether~~ if the university, college, department, school, or institute had institutional catalogues and brochures that specified its intent to educate and train psychologists, at the commencement of the applicant's degree program~~.~~;
2. ~~To determine whether a~~ A program "stands as a recognized, coherent organizational entity" ~~pursuant to~~ under A.R.S. § 32-2071(A)(2), ~~the Board shall determine whether~~ if the university, college, department, school, or institute had a psychology curriculum that was an organized sequence ~~of study~~ of courses at the commencement of the applicant's degree program~~.~~; and
3. ~~To determine whether a~~ A program has "clearly identified entry and exit criteria" within its curriculum ~~pursuant to~~ under A.R.S. § 32-2071(A)(2), ~~the Board shall examine whether~~ if the university, college, department, school, or institute has ~~entry~~ requirements that outline the prerequisites for entrance into the program and the sequence of study and ~~whether the~~ has requirements for graduation ~~are~~ delineated.

~~4. To determine whether a comprehensive examination taken by an applicant as part of a doctoral program in psychology satisfies the requirements of A.R.S. § 32-2071(A)(4), the applicant shall have the educational institution that granted the doctoral degree provide documentation, directly to the Board, which demonstrates how the applicant's comprehensive examinations were constructed, the criteria for passing, and the information used to determine that the applicant passed.~~

~~5~~**B.** ~~To determine whether an applicant satisfies the requirements of A.R.S. § 32-2071(A)(4) by successfully completing at least three or more graduate level semester hours, or the equivalent quarter hours, in the content areas required by~~ The Board shall verify that an applicant has completed the hours in the subject areas described in A.R.S. § 32-2071(A)(4)~~(a) through (h),~~. For this purpose, the applicant shall have the institution that the applicant attended provide~~,~~ directly to the Board~~,~~ an official transcript of all courses taken.

1. The Board shall verify that an applicant's transcripts have been prepared solely by the institution under A.R.S. § 32-2071(A)(7), by determining whether the applicant had any input into the transcript drafting process.
2. The Board may require additional documentation from the applicant or from the institution to determine ~~if~~ whether the applicant has satisfied the requirements of A.R.S. § 32-2071(A)(4).

~~B. The residency requirement of A.R.S. § 32-2071(I) shall be construed as being applicable to the applicant's graduate program at the institution granting the doctoral degree.~~

C. To determine whether a comprehensive examination taken by an applicant as part of a doctoral program in psychology satisfies the requirements of A.R.S. § 32-2071(A)(4), the Board shall review documentation provided directly to the Board by the educational institution that granted the doctoral degree, that demonstrates how the applicant's comprehensive examination was constructed, lists criteria for passing, and provides the information used to determine that the applicant passed.

~~C~~**D.** The Board shall not accept credit hours ~~for life experiences,~~ for workshops, ~~practicum~~ practica, or undergraduate courses from any degree-granting university or institution of higher education, for life experiences, or for credits transferred from institutions that are not accredited ~~pursuant to~~ under A.R.S. § 32-2071(A)(1), to satisfy a requirement of A.R.S. § 32-2071(A)(4).

~~D~~**E.** ~~No~~ The Board shall count a course or comprehensive examination ~~shall be counted more than~~ only once to satisfy a requirement of A.R.S. § 32-2071(A)(4).

~~E~~**F.** An honorary doctorate ~~or other~~ degree ~~based upon credit granted for life experiences~~ does not qualify an applicant for ~~certification~~ licensure as a psychologist.

G. The Board shall not accept as core program credits practica, workshops, continuing education courses, experiential or correspondence courses, or life experiences. The Board shall accept core program credits for seminar or readings courses and independent study only if the applicant provides substantiation that the course was an in-depth study devoted to a particular core area. The applicant shall substantiate through 1 or more of the following:

1. Course description in official college catalogue,
2. Course syllabus, or
3. Signed statement from a dean or psychology department head detailing that the course was an in-depth study devoted to a particular core area.

R4-26-203. ~~Evaluation of Applicant Credentials~~ Application for Licensure

A. ~~An applicant for licensure shall submit for Board review the following information for the Board to determine the applicant's eligibility to take the Board's examinations or to have such examinations waived:~~

~~1. Pursuant to A.R.S. § 32-2063(A)(3), the Board's application form completed and signed by the applicant and notarized. This form requires the following applicant information:~~

~~a. Name, addresses, and telephone numbers;~~
~~b. Educational background and training;~~
~~c. Licensing and disciplinary history;~~
~~d. Employment history;~~
~~e. Membership in professional associations;~~
~~f. Criminal and malpractice history;~~
~~g. Medical history; and~~
~~h. Photographs.~~

~~2. Pursuant to A.R.S. § 32-2063(A)(3), as part of the content of the application, favorable written references of the applicant confirming, to the best knowledge of the person issuing the reference, that the applicant has not engaged in any act or conduct that constitutes grounds for disciplinary action against a licensee of the Board pursuant to A.R.S. § 32-2071.01(3) from two professional references familiar with the applicant. Providing references who indicate only that they know the applicant or are not aware of an unfavorable report concerning the applicant does not constitute credentials necessary for licensure. The reference shall be from individuals who are either Arizona licensed psychologists, diplomates, or fellows or members in good standing of the American Psychological Association, Canadian Psychological Association, or the American Psychological Society and who have knowledge of the applicant's professional activities within the three years prior to the date of submission of the applicant's application. If it has been more than three years since the applicant has engaged in professional activity as a psychologist or as a doctoral candidate in psychology, then the applicant may submit references from individuals who have the same credentials described previously herein and who have knowledge of the applicant's aforementioned activity, as a psychologist or as a doctoral candidate, for the most recent three-year period that the applicant engaged in the aforementioned activity. If none of the foregoing persons are available to the applicant, other psychologists who are licensed or certified to practice psychology in the United States or Canada who have knowledge of the applicant's professional activities within the three years prior to the date of submission of the applicant's application shall be acceptable.~~

~~3. Pursuant to A.R.S. § 32-2071(A), official transcripts covering the applicant's graduate training. These transcripts shall be sent to the Board by the institution and shall contain a notation of degrees awarded or be accompanied by an official notice of the date and name of the degrees awarded and the name of the department awarding the degrees.~~

~~4. An affidavit from the supervisor or administrator of the applicant's supervised internship or training program verifying that the applicant's training satisfied the requirements of A.R.S. § 32-2071(D).~~

~~5. An affidavit from the supervisor of the applicant's postdoctoral experience verifying that the applicant's postdoctoral experience satisfied the requirements of A.R.S. § 32-2071(E).~~

~~6. A written description from the applicant of the components of the applicant's doctoral program to show that the applicant's doctoral program satisfied the core program requirements of A.R.S. § 32-2071(A)(4).~~

~~7. A signed, written statement from the applicant that the applicant has completed a residency that satisfies the requirements of A.R.S. § 32-2071(I) in its entirety.~~

An applicant for a psychologist license shall submit an application packet to the Board that includes an application form, provided by the Board, signed and dated by the applicant, and notarized, that contains the following information:

1. Applicant's name, business and home addresses, social security number, business and home telephone numbers, and date and place of birth;
2. Whether the applicant is a diplomate of the American Board of Professional Psychology;
3. Name of each jurisdiction in which the applicant is currently or has been licensed as a psychologist;
4. Whether the applicant has applied for licensure as a psychologist in any other jurisdiction and date of each application;
5. Whether the applicant is licensed or certified in a profession or occupation other than psychology;
6. Whether the applicant has ever taken the national examination in psychology, name of each jurisdiction in which taken, and each date of examination;
7. Whether the applicant has ever had an application for a professional license, certification, or registration denied or rejected by any jurisdiction;
8. Whether the applicant has ever had disciplinary action initiated against the applicant's professional license, certification, or registration, or had a professional license, certification, or registration suspended or revoked by any jurisdiction;
9. Whether the applicant has ever entered into a consent agreement or stipulation arising from a complaint against any professional license, certification, or registration;
10. Whether the applicant is a member of any professional association in the field of psychology and name of association;
11. Whether the applicant has ever had membership in a professional association in the field of psychology denied or revoked;
12. Whether the applicant is currently under investigation for or has been found guilty of violating a code of professional ethics of any professional organization;
13. Whether the applicant is currently under investigation for or has been found guilty of violating a code of unprofessional conduct by any jurisdiction;
14. Whether the applicant has ever been sanctioned or placed on probation by any jurisdiction;
15. Whether the applicant has been convicted of a felony or a misdemeanor other than a minor traffic offense, or has ever entered into a diversion program in lieu of prosecution, including any convictions that have been expunged or deleted;

16. Whether the applicant has been sued in civil or criminal court pertaining to the applicant's practice as a psychologist, the applicant's work under a certificate or license in another profession, or the applicant's work as a member of a particular profession;
17. Whether the applicant is currently addicted to alcohol or any drug that in any way impairs or limits the applicant's ability to practice;
18. Whether the applicant has any medical, physical, or psychological condition that may in any way currently impair or limit the applicant's ability to practice psychology safely and effectively;
19. Name and address of each university or college from which the applicant graduated, date of attendance, date of graduation, degree received, name of department, and major subject area;
20. Major advisor's name and department and the title of the applicant's dissertation or Psy.D. project for the doctoral degree;
21. Official title of the doctoral degree program or predoctoral specialty area;
22. Whether the predoctoral internship was an American Psychological Association approved program or an Association of Psychology and Postdoctoral Internship Center program;
23. Each location at which the applicant participated in an internship training program and each supervisor's name;
24. Areas of professional competence;
25. Intended area of professional practice in psychology;
26. Name, position, and address of at least 2 references who:
    a. Are licensed psychologists, diplomates of the American Board of Professional Psychology, fellows or members in good standing of the American Psychological Association, Canadian Psychological Association, or American Psychological Society, or other psychologists who are licensed or certified to practice psychology in a United States or Canadian jurisdiction and who are not members of the Arizona Board of Psychologist Examiners;
    b. Are familiar with the applicant's work experience in the field of psychology or postdoctoral program within 3 years immediately preceding the date of application. If more than 3 years have elapsed since the applicant last engaged in professional activities in the field of psychology or in a postdoctoral program, the references may be from the most recent 3-year period in which the applicant engaged in professional activities in the field of psychology or in a postdoctoral program; and
    c. Recommend the applicant for licensure;
27. History of employment in the field of psychology including the beginning and ending dates of employment, number of hours worked per week, name and address of employer, name and address of supervisor, and type of employment in the field of psychology;
28. Whether the applicant is requesting a temporary license under A.R.S. § 32-2073, if applicable;
29. Information to demonstrate that the applicant satisfied the core program requirements in A.R.S. § 32-2071(A)(4) and R4-26-202;
30. A notarized statement, verified under oath by the applicant, that the information on the application pertains to the applicant, is true and correct, and has not been procured through fraud or misrepresentation;
31. Two photographs of the applicant no larger than 1-1/2 X 2 inches taken not more than 60 days before the date of application;
32. Fee required by the Board; and
33. Any other information authorized by statute.

B. ~~If seeking waiver of the written examination for the practice of psychology based upon previous testing, the applicant shall request the Professional Examination Service to send the applicant's previous test scores directly to the Board.~~ In addition to the requirements of subsection (A), an applicant for a psychologist's license shall arrange to have directly submitted to the Board:

1. An official transcript from each university or college from which the applicant has received a graduate degree and the date received;
2. An official document from the degree-granting institution indicating that the applicant has completed a residency that satisfies the requirements of A.R.S. § 32-2071(H) in its entirety;
3. An affidavit from the applicant's supervisor if available or a psychologist knowledgeable of the applicant's internship training program, verifying that the applicant's internship training program meets the requirements in A.R.S. § 32-2071(D); and
4. An affidavit from the applicant's postdoctoral supervisor if available or a psychologist knowledgeable of the applicant's postdoctoral experience verifying that the applicant's postdoctoral experience meets the requirements in A.R.S. § 32-2071(E).

C. ~~If seeking waiver of the Board's written examination based upon diplomate status, the applicant shall request the American Board of Professional Psychology to send verification of such status directly to the Board.~~ In addition to the requirements in subsections (A) and (B), for approval to sit for the additional examination, an applicant shall ensure that an official notification of the applicant's score on the national examination is provided to the Board.

1. An applicant who has passed the national examination and is seeking an exemption under A.R.S. § 32-2072(C) shall have the examination score sent directly to the Board by the professional examination service.
2. An applicant who is seeking an exemption under A.R.S. § 32-2072(C) due to the applicant's status as a diplomate of the American Board of Professional Psychology shall arrange to have a verification of diplomate status sent directly to the Board by the American Board of Professional Psychology.

R4-26-204. Examinations

A. General Rules

1. The Board administers the national examination and may administer the additional examination.

~~1~~2. Under A.R.S. § 32-2072(B), an applicant who fails an examination ~~three~~ 3 or more times, in Arizona or any other jurisdiction, shall comply with the following requirements ~~pursuant to A.R.S. § 32-2072(B)~~ before taking another examination:

a. ~~No further examinations shall be administered in Arizona and no future scores from any other jurisdiction shall be considered until the~~ The applicant ~~meets~~ shall meet with the Board to review the areas of deficiency and to develop and implement a program of study and practice experience designed to remedy the applicant's deficiencies. This remedial program ~~shall~~ may consist of course work, self study, internship experience, supervision, or any combination of these.

b. ~~A new license application shall be submitted~~ An applicant shall submit a new license application only after completion of the remedial program described in subsection (A)(~~1~~2)(a). In addition to the information ~~that was~~ required on the original application, ~~this~~ the new application shall include documentation of all professional activities of the applicant since the date of the original application.

~~c. If the applicant who fails an examination three or more times subsequently passes an Arizona - approved examination in another jurisdiction at or above the passing score required in Arizona on the date the examination was taken, the Board shall not accept a new application as complete until the applicant completes the remedial program described in subsection (A)(1)(a).~~

~~2~~3. If an applicant who has been accepted to sit for a Board examination fails to appear at the time scheduled for the commencement of the examination or any ~~specific parts~~ part ~~thereof~~ of the examination, the applicant ~~loses~~ shall lose eligibility to sit for that examination ~~and shall reapply and pay another application fee~~.

~~3~~4. The Board ~~may~~ shall deny a license ~~on the grounds that an applicant has violated or attempted to violate the restrictions governing any licensing examination or the administration of an examination, as listed hereafter:~~ if an applicant commits any of the following acts:

a. ~~Violating~~ Violates the security of the examination materials;
b. ~~Removing~~ Removes any examination materials from the examination room ~~any examination materials~~;
c. ~~The xerographic, photographic, or other reproduction of~~ Reproduces any portion of the licensing examination;
d. ~~Aiding the xerographic, photographic, or other mechanical~~ Aids in the reproduction or reconstruction of any portion of the licensing examination;
e. ~~Paying or using~~ Pays or uses another person to take a licensing examination for the applicant or to reconstruct any portion of the licensing examination;
f. ~~Obtaining~~ Obtains examination material, either before, during, or after an examination, or ~~using or purporting~~ uses or purports to use any examination materials which were removed or taken from any examination for the purpose of instructing or preparing applicants for examinations;
g. ~~Selling, distributing, buying, receiving, or having~~ Sells, distributes, buys, receives, or has possession of any portion of a future, current, or previously administered licensing examination that ~~has~~ is not ~~been~~ authorized for release to the public by the Board or its authorized agent;
h. ~~Communicating~~ Communicates with any other examinee during the administration of a licensing examination;
i. ~~Copying~~ Copies answers from another examinee or ~~permitting answers to be copied~~ permits the copying of answers by another examinee;
j. ~~Possessing~~ Possesses during the administration of the licensing examination any books, equipment, notes, written or printed materials, or data of any kind, other than material distributed during the examination; or
k. ~~Impersonating~~ Impersonates another examinee.

B. ~~Written~~ National Examination

1. ~~Pursuant to~~ Under A.R.S. §§ 32-2063 and 32-2072, the Board shall administer ~~the~~ a national ~~written~~ examination ~~for the licensure of a psychologist~~ provided by the Association of State and Provincial Psychology Boards for the licensure of a psychologist. An applicant ~~whose credentials were~~ approved by the Board to take a national examination ~~shall be considered to have passed~~ passes the ~~test~~ examination if the applicant's score ~~received~~ equals or exceeds ~~at least 70% of the total possible score~~ the passing score recommended by the Association of State and Provincial Psychology Boards. The Board shall notify the applicant ~~shall be notified~~ in writing of the ~~test~~ examination results ~~as provided to the Board by~~ when the Board receives the results from the ~~testing service~~ Association of State and Provincial Psychology Boards.

2. ~~No inspection is allowed of a written examination administered by the~~ The Board shall not allow inspection of a national examination.

C. ~~Oral~~ Additional Examination

1. An applicant shall pass a national examination before being permitted by the Board to take the additional examination.
~~1~~2. ~~The oral examination, pursuant to~~ Under A.R.S. § 32-2072(A), ~~shall consist of a panel of two or more examiners asking each applicant questions~~ the Board may administer an additional examination to all applicants to determine the ~~competency~~ adequacy of the applicant's knowledge and application of Arizona law. The additional examination may also cover ~~to~~ the practice of psychology, ethical conduct, and psychological assessment and treatment practices. ~~The panel of examiners shall be chosen by the Board from a group of Arizona licensed psychologists.~~
   a. The Board may review and approve the additional examination before administration. The additional examination may be developed by the Board, a committee of the Board, consultants to the Board, or independent contractors.
   b. The additional examination may be administered by the Board, a committee of the Board, consultants to the Board, or independent contractors.
   c. Applicants, examiners, and consultants to the Board shall execute a security acknowledgment form stating that they shall maintain examination security.
~~2.~~ ~~At least 15 calendar days prior to the oral licensing examination, the Board shall notify the applicant by correspondence, that is addressed to the applicant's address of record, of the subject areas to be tested and the applicant shall be examined only in those areas. Failure of the applicant to receive the aforementioned notification shall not constitute grounds for excusing the applicant from taking the scheduled oral examination. Applicants are responsible for communicating with the Board's administrative staff to obtain the aforementioned notification, notwithstanding the Board's intent to give notice by mail.~~
   ~~a.~~ ~~An applicant shall be deemed to have passed the oral examination if the score obtained is at least 75% of the total possible score. Applicants shall be notified in writing of their examination results. An applicant who fails to receive a score of at least 75% of the total possible score in an oral examination shall be given reasons in writing why the failing score was issued.~~
   ~~b.~~ ~~The Board shall keep a recording at the Board office of each oral examination for at least two years following the date of the examination.~~
   ~~c.~~ ~~Scoring of the oral examination shall be performed by each examiner on the panel on uniform grading sheets provided by the Board. The mean score, calculated by averaging the score given by each examiner on the panel, shall constitute the applicant's final score. Only the mean score, not the score assigned by each of the examiners on the panel, shall be disclosed to the applicant.~~
   ~~d.~~ ~~An applicant who believes that an examiner on the oral examination panel may be biased against or for the applicant's application shall notify the person administering the examination as soon as the applicant becomes aware of the perceived bias.~~
~~3.~~ ~~All requests for reconsideration of the results of an oral examination shall be submitted in writing to the Board office within 30 days following the notification of failure of the examination.~~
   ~~a.~~ ~~Upon timely request by an applicant, the Board shall reconsider the results of a failed oral examination if the applicant received a score between 72.5% and 74.9% of the total possible score. The Board may reconsider the results of an oral examination if the applicant received a score of less than 72.5% of the total possible score.~~
   ~~b.~~ ~~The review for reconsideration of an oral examination shall be conducted by one or more of the Board members and their findings shall be subject to the approval of the Board at the next regularly scheduled Board meeting.~~
   ~~c.~~ ~~Nothing in this Section shall be construed to deprive an applicant of the applicant's appeal rights provided by law.~~
~~4.~~ ~~All examination materials, except those owned by an examination service, shall be retained by the Board at the Board office for a period of two years after the date of the examination. An applicant may inspect an oral examination grading sheet or the recording of an oral examination at the Board office during the hours of 8 a.m. to 5 p.m., Monday through Friday, excluding holidays, if such request is made in writing to the Board within one year following the date of the examination. No more than one inspection shall be allowed prior to the expiration of the time to file a written request for reconsideration. Applicants who were informed that they passed the oral examination, or failing applicants who do not wish to request Board reconsideration, shall be allowed to inspect once an oral examination grading sheet or the recording of an oral examination at the Board's offices after the time has expired for failing applicants to submit requests for reconsideration. At the time of inspection, only the person who took the examination and a representative of the Board shall be present.~~
~~5.~~ ~~Diplomates and applicants who received a passing score on a previous written examination pursuant to A.R.S. § 32-2072B are exempt from the written examination but shall take the oral examination.~~
~~6.~~ ~~An applicant shall pass the written examination before being permitted by the Board to take the oral examination.~~

R4-26-205. Renewal of License

A. ~~License~~ The Board considers license renewal applications ~~shall be considered~~ timely filed ~~received by the Board~~ if delivered to the Board's office and ~~received by the Board's personnel or if mailed to the Board's address by the United States mail and~~ date stamped or postmarked before May 1 of the year that the license expires.

B. A renewal application form provided by the Board, signed and dated by the licensee, shall contain:
1. Applicant's name, business and home addresses, social security number, license number, business and home telephone numbers, gender, date of birth, and preference designation for directory and mailing addresses;
2. Whether the applicant is currently licensed or certified as a psychologist in another jurisdiction, and if so, where;
3. Whether the applicant is currently a licensed or certified member of another profession, and if so, which profession and where;
4. Whether the applicant is a diplomate of the American Board of Professional Psychology, and if so, in which specialties;
5. Whether the applicant is a fellow, member, or associate of the American Psychological Association;
6. Whether the applicant is a member of other professional associations and if so, which ones;
7. Whether the applicant is a member of any hospital staff or provider panel and if so, which ones;
8. Whether the applicant has completed the required 60 hours of continuing education; and if not, an explanation of the reasons;
9. Whether the applicant has been denied a license or certificate to practice any profession by any state or Canadian province;
10. Whether the applicant has ever relinquished responsibilities, resigned a position, or been fired while a complaint was pending against the applicant;
11. Whether the applicant has ever resigned or been terminated from a professional organization, hospital staff, or provider panel or surrendered a license while a complaint against the applicant was being investigated or adjudicated;
12. Whether the applicant has been disciplined by any agency or regulatory board of a state or Canadian province, or by any professional organization, hospital staff, or provider panel for acts pertaining to the applicant's conduct as a psychologist or as a professional in any other field, and if so, a report of those actions including the name and address of the disciplinary agency, the nature of the action, and a statement of the charges and findings;
13. Whether the applicant has been convicted of a felony or a misdemeanor other than a minor traffic offense in any state or country;
14. Whether the applicant is currently under investigation by any professional organization, hospital staff, or provider panel of which the applicant is a member or governmental regulatory board or agency concerning the ethical or legal propriety of the applicant's conduct;
15. Whether the applicant has been sued in civil or criminal court pertaining to the applicant's practice as a psychologist, the applicant's work under a license or certificate in another profession, or the applicant's work as a member of a particular profession;
16. Whether the applicant is delinquent in payment of a judgment for child support;
17. Whether the applicant has had an application for membership to any professional organization rejected, or has had any professional organization, ethics committee, or health care institution suspend or revoke the applicant's membership or placed the applicant on probation or otherwise censured the applicant for unethical or unprofessional conduct or other violation of eligibility or membership requirements;
18. Whether the applicant has any condition that in any way impairs or limits the applicant's ability to practice psychology safely and effectively in Arizona;
19. Whether the applicant is requesting any of the following inactive status options:
    a. Mental or physical disability,
    b. Voluntary inactive status,
    c. Retirement, or
    d. Medical or inactive continuation;
20. Whether the applicant is requesting expired status;
21. A signed attestation of the veracity of the information provided; and
22. Any other information authorized by statute.

C. A licensee who applies for renewal in a timely manner, but fails to complete the required 60 hours of continuing education, may reinstate an expired license and continue practicing between May 1 and July 1 by paying a reinstatement fee in addition to the regular renewal fee, under A.R.S. § 32-2074(B). The licensee shall complete the continuing education requirements by July 1st of the same year.

D. A licensee who fails to complete the required 60 hours of continuing education by July 1st and reinstate a license under subsection (C) may have from July 1st of the renewal year to May 1st of the next year to complete the continuing education requirements by paying an additional delinquent compliance fee.

E. If as a result of an audit of continuing education records, the Board disallows some or all of a licensee's credit hours for failure to conform to the standards listed in R4-26-207, and the remaining hours are less than the number required, the Board shall deem the licensee as failing to satisfy the continuing education requirements. The licensee shall have 90 days from the mailing date of notification of disallowance to complete the continuing education requirements for the past reporting period and, upon completion shall provide the Board with an affidavit documenting how the disallowance has been cured. If the Board does not receive an affidavit of cure within 90 days of the mailing date of notification of disallowance, or the Board deems the affidavit insufficient, the Board may proceed to take disciplinary action under A.R.S. § 32-2081.

R4-26-207. Continuing Education

A. A licensee shall complete a minimum of 60 hours of continuing education shall be completed during each two-year 2-year license renewal period. One clock hour of instruction, training, preparation of a published book or journal article, or making a presentation shall equal equals one 1 continuing education credit.

1. For newly licensed individuals, during any license renewal period, the continuing education requirement shall be prorated from the time of a new applicant's licensure. Psychologists licensed for less than 2 years shall accrue continuing education credit based on the number of weeks remaining between the date of their licensure and May 1 of the next renewal year.
2. The date of Board correspondence giving new licensees notice of official licensure shall be the time from which the prorating of the continuing education requirement shall begin for a new licensee. The prorating of the continuing education requirement shall be calculated by counting, from the week following the date of licensing of a new licensee, the number of weeks remaining until May 1 of the next renewal year. That number shall serve as a numerator of a fraction, and 104, the total number of weeks in the renewal period, shall be the denominator of the fraction. This fraction shall then be multiplied by 60, the total number of continuing education hours required, to calculate the minimum number of continuing education hours required for the license renewal period. Continuing education hours are prorated from the date of the Board correspondence notifying a new licensee of licensure. To calculate the number of continuing education hours that a new licensee must obtain:
   a. Count the number of weeks between the week following the date of new licensure notification and May 1 of the next renewal year;
   b. Divide the number of weeks by 104, the total number of weeks in the renewal period; and
   c. Multiply that number by 60, the total number of continuing education hours required.
3. The same fraction shall be is used to calculate the minimum number of continuing education hours required in each of the three categories listed in subsection (B). Calculations that result in a fractional number shall be are rounded to the next largest whole number.

B. During the two 2-year license period, a licensee shall obtain a minimum of 40 hours from Category I as described hereafter; and, no more than in subsection (B)(1). The other 20 required continuing education hours may be from Category I or Category II to satisfy the total number of hours of instruction during the two-year license period.

1. Category I shall consist of courses, seminars, workshops, home studies with certificates of completion, and post-doctoral studies includes:
   a. A course, seminar, workshop, or home study with certificate of completion, and post-doctoral study sponsored by a regionally accredited university or college, as described listed in A.R.S. § 32-2071(A)(1), providing that provides a graduate-level degree program; or
   b. A continuing education programs offered by national, international, regional, or state associations, societies, boards, or continuing education providers, if:
      i. At least 75% of the content of the educational experience is primarily (for example, 75% or more) concerning subjects related to the "practice of psychology", as defined in A.R.S. § 32-2061(A)(8).; and
      ii. Instructors shall meet A program's instructor meets the qualifications stated in subsection (C).;
   c. Attending a Board meeting. A licensee shall receive 4 continuing education hours for attending a full-day Board meeting and 2 continuing education hours for attending a 1/2 day Board meeting. These Board-approved continuing education hours may not be accepted outside the State of Arizona. A licensee shall complete documentation provided by the Board at the time of Board meeting attendance. The Board shall accept no more than 10 continuing education hours obtained by attending a Board meeting from a licensee for each renewal period; or
   d. Serving as a complaint consultant. A licensee who serves as a Board complaint consultant may receive continuing education hours equal to the actual number of hours served as a complaint consultant up to a maximum of 20 continuing education hours per renewal period. Continuing education hours received for complaint consultation may not be accepted outside the State of Arizona.
2. Category II shall consist of includes self study,; study groups,; publication of authored or co-authored psychology books or psychology book chapters,; or publication of articles in peer-reviewed psychology journals,; or presentation of symposia or papers at a state, regional, national, or international psychology meeting,; or attendance at or participation in case conferences.

C. ~~Qualifications of continuing education instructors shall be~~ A continuing education instructor's qualifications are subject to unannounced review by the Board. A continuing education instructor~~s~~ shall:
   1. ~~either be~~ Be currently licensed or certified in ~~their~~ the instructor's profession or ~~employed as a faculty member, working~~ work at least 20 hours ~~a~~ each week~~,~~ as a faculty member at a regionally accredited college or university, as ~~described~~ listed in A.R.S. § 32-2071(A)~~,~~;
   2. ~~be~~ Be a fellow ~~of the American Psychological Association or American Psychological Society,~~ as defined in R4-26-101 or a diplomate as defined ~~by R4-26-101(4).~~ in R4-26-101; or
   3. Demonstrate competence and expertise in the subject or material the instructor teaches by having an advanced degree, teaching experience, work history, authored professional publication articles, or presented seminars in that subject or material.

D. A ~~psychologist licensed by the Board~~ licensee who organizes and presents a ~~workshop, seminar, symposium, or course for continuing education credits~~ continuing education activity shall receive the same number and category~~, reflected in subsections (B)(1) or (2),~~ of continuing education ~~credits~~ hours described in subsection (B) as those persons attending the continuing education function. ~~Credit shall be applied~~ The Board shall allow credit only once in a ~~two~~ 2-year license renewal period for organizing and presenting a continuing education function on the same topic or content area.

E. ~~Psychologists~~ A licensee elected to ~~offices~~ an officer position in an international, national, regional, or state psychological association~~s~~ or ~~societies~~ society, or appointed to a government psychology board~~s~~ or committee~~s,~~ ~~may~~ shall receive a maximum of ~~ten~~ 10 Category I continuing education ~~credits~~ hours for each renewal cycle ~~under Category I, reflected in subsection (B)(1),~~ for ~~their~~ the licensee's work in ~~those positions~~ the position.

F. Each licensee shall keep ~~records to demonstrate to the Board~~ documents that substantiate completion of continuing education ~~credits~~ hours for the ~~two~~ 2 previous, consecutive, license renewal periods. Documents that verify continuing education completion shall include a certificate of attendance, statement signed by the provider verifying participation in the activity, official transcript, or documents indicating a licensee's participation as an elected officer or appointed member as specified in subsection (E). The Board shall accept a signed affidavit to document self study activity which includes a description of the activity, the subject covered, the dates, and the number of hours involved.

G. The Board may audit a licensee's compliance with continuing education requirements. ~~Failure~~ The Board may deny renewal or take other disciplinary action against a licensee who fails to document required continuing education hours ~~credits may result in nonrenewal of a license or other disciplinary action~~. A licensee who commits fraud, deceit, or misrepresentation regarding continuing education ~~credits~~ hours may be disciplined by the Board.

H. A licensee who cannot meet the continuing education requirement for good cause may ~~submit a written request to the Board, with all appropriate fees, seeking~~ seek an extension of time to complete the continuing education requirement by submitting a written request to the Board, including the renewal fee.
   1. Good cause ~~shall be~~ is limited to licensee illness, military service, or residence in a foreign country for at least 12 months of the license renewal period.
   2. A licensee shall submit a request for extension ~~Requests for extensions shall be submitted~~ on or before the expiration of a license, as provided by statute. A time extension shall not exceed one year.
   3. ~~Licensees~~ A licensee who cannot complete the continuing education requirement within the time extension may apply to the Board for inactive license status ~~pursuant to~~ under A.R.S. § 32-2073(E).

I. The Board shall not allow continuing ~~Continuing~~ education hours in excess of the 60 required hours ~~shall not~~ to be carried beyond the ~~two-year~~ 2-year renewal period in which they were accrued.

J. Courses, workshops, seminars, or symposia designed to increase income or office efficiency ~~shall~~ are not ~~be~~ eligible for continuing education ~~credits~~ hours.

R4-26-208. Time-frames for Processing Applications

A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of approval granted by the Board is listed in Table 1. An applicant and the Board's Executive Director may agree in writing to extend the substantive review time-frame and the overall time-frame. Any extension shall not exceed 25% of the overall time-frame.

B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of approval granted by the Board is listed in Table 1.
   1. The administrative completeness review time-frame begins, for approval or denial:
      a. To take the national examination, on the date the Board office receives an application packet and ends on the date the Board office sends an applicant a written notice of administrative completeness;
      b. To take the additional examination, if applicable, on the date the Board office receives an application packet for an additional examination, and ends on the date the Board office sends an applicant a written notice of administrative completeness of the additional examination packet;
      c. Of a temporary license for an applicant licensed in another jurisdiction, on the date the Board office receives an application packet from the applicant and ends on the date the Board office sends the applicant a written notice of administrative completeness;
      d. Of a license, on the date an applicant takes the additional examination and ends on the date the Board office notifies the applicant that the applicant has completed the additional examination;

e. Of a license renewal application, on the date the Board office receives a renewal application packet and ends on the date the Board office sends an applicant a written renewal approval or a written notice of completeness, whichever comes first;

f. Of a request for reinstatement of an expired license, on the date the Board office receives the request for reinstatement and ends on the date the Board office sends an applicant a written renewal approval or a written notice of completeness, whichever comes first; and

g. Of a request for an extension in which to complete continuing education requirements, on the date the Board office receives a request for extension, and ends on the date the Board office sends an applicant written notice of completeness of the request.

2. If an application packet is incomplete, the Board shall send an applicant a written notice specifying the missing document or incomplete information. The administrative completeness review time-frame and the overall time-frame are suspended from the date of mailing this notice until the date the Board receives a complete application packet from the applicant. An applicant shall supply the missing information within the time specified in Table 1 from the date of the notice. If the applicant fails to do so, the Board may close the file unless the applicant requests a denial of the application within 30 days from the date of the notice. An applicant whose file has been closed and who later wishes to become licensed shall reapply.

3. If a renewal application is incomplete, the Board shall send an applicant a written notice specifying deficiencies. The administrative completeness time-frame and the overall time-frame are suspended from the date of mailing this notice until the date Board receives a complete application packet from the applicant.

4. Once an application packet is complete, the Board shall send a written notice of administrative completeness to an applicant.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is listed in Table 1.

1. The substantive review time-frame begins for approval or denial of:

a. An application to take the national examination, on the date the Board sends an applicant written notice of administrative completeness and ends on the date the Board approves or denies the application to take the national examination;

b. An application to take the additional examination, on the date the Board sends the applicant written notice of administrative completeness and ends on the date the Board approves or denies the application to take the additional examination;

c. A temporary license, on the date the Board sends an applicant written notice of administrative completeness and ends on the date the Board approves or denies the temporary license;

d. A license, on the date the Board sends an applicant written notification that the applicant has completed the additional examination, if applicable, and ends on the date the Board ~~grants~~ approves or denies the ~~license~~ application;

e. An application for license renewal, on the date an applicant submits a complete renewal application packet and ends on the date the Board approves or denies the renewal application;

f. A request for reinstatement of an expired license, on the date the Board sends written notice of administrative completeness and ends on the date the Board approves or denies the request; and

g. A request for an extension in which to complete continuing education requirements, on the date the Board office sends an applicant written notice of completeness and ends on the date the Board approves or denies the request.

2. During the substantive review time-frame, the Board may make 1 comprehensive written request for additional information or documentation. The time-frame for the Board to complete the substantive review is suspended from the date of mailing the comprehensive written request for additional information or documentation until the Board receives the additional information or documentation.

D. The Board shall send a written notice of approval to an applicant who meets the qualifications in A.R.S. § 32-2071 through § 32-2076.

E. The Board shall send a written notice of denial to an applicant who fails to meet the qualifications in A.R.S. § 32-2071 through § 32-2076.

F. The Board shall send a renewal certificate to an applicant who meets the requirements of A.R.S. § 32-2074 and R4-26-205.

G. The Board shall send a written notice of expiration of license to an applicant who fails to meet the requirements of A.R.S. § 32- 2074 and R4-26-207. The notice of expiration is fully effective upon mailing to the applicant's last known address of record in the Board's file.

H. If a time-frame's last day falls on a Saturday, Sunday, or an official state holiday, the time-frame ends on the next business day.

Table 1. Time-frames (in Days) for Processing Applications

Type of Time-frame	Statutory or Rule Authority	Administrative Completeness Time-frame	Time to Respond to Notice of Deficiency	Substantive Review Time-frame	Time to Respond to Request for Additional Information	Overall Time-frame
Approval or denial to take the national examination	A.R.S. § 32-2071; § 32-2071.01; § 32-2072; R4-26-204	30	240	60	240	90
Approval or denial to take additional examination	A.R.S. § 32-2071; § 32-2071.01; § 32-2072; R4-26-204	30	240	60	240	90
Approval or denial to issue temporary license	A.R.S. § 32-3071 A.R.S. § 32-2073	30	240	60	240	90
Approval or denial for licensure	A.R.S. § 32-2071; § 32-2071.01	30	240	60	240	90
Approval or denial of application for renewal of license	A.R.S. § 32-2074 R4-26-205	60	No time specified	90	No time specified	150
Approval or denial of renewal application for reinstatement	A.R.S. § 32-2074; R4-26-206	60	No time specified	90	No time specified	150
Approval or denial of extension for continuing education requirement	A.R.S. § 32-2074 R4-26-207	60	No time specified	90	No time specified	150

R4-26-209. General Supervision

~~In the context of supervised activity referred to in~~ Under A.R.S. § 32-2071, a supervising ~~psychologists~~ psychologist shall not supervise a member of ~~their~~ the psychologist's immediate family, an individual with whom ~~they have~~ the psychologist has any substantial financial interest as defined by ~~A.R.S. § 32-502(11)~~ A.R.S. § 38-502(11), or ~~their~~ the psychologist's employer.

R4-26-210. Internship or Training Experience

The Board shall use the following criteria to determine if internship or training experience complies with A.R.S. § 32-2071(D):

~~A.~~ 1. ~~The applicant shall provide documentation to establish that~~ That the written statement required in A.R.S. § 32-2071(D)(9) corresponds to the training program that the applicant completed~~.~~;

~~B.~~ 2. ~~Pursuant to A.R.S. § 32-2071(D)(2),~~ That ~~the~~ a supervisor ~~shall be~~ was available to the person being supervised when decisions ~~are~~ were made regarding emergency psychological services provided to a client as required in A.R.S. § 32-2071(D)(2);~~.~~

~~C. Pursuant to A.R.S. § 32-2071(D)(2), in non-emergency situations, the supervisor shall have written procedures to be followed in the event the supervisor is unavailable;~~

~~D.~~ 3. ~~Course~~ That course work used to satisfy the requirements of A.R.S. § 32-2071(A) or dissertation time ~~shall not be~~ is not credited toward the time required by A.R.S. § 32-2071(D)(6);

~~E.~~ 4. ~~Pursuant to A.R.S § 32-2071(D)(6)(a), two~~ That the 2 hours a week of other learning activities required in A.R.S. § 32-2071(D)(6) ~~may include~~ includes 1 or more of the following:

- ~~1~~a. Case conferences involving a case in which the trainee was actively involved~~;~~,
- ~~2~~b. Seminars involving clinical issues~~;~~,
- ~~3~~c. Co-therapy with a professional staff person including discussion~~;~~,
- ~~4~~d. Group supervision~~;~~, or
- ~~5~~e. Additional individual supervision;

~~F.~~ 5. ~~Pursuant to A.R.S. § 32-2071(D)(7),~~ That a training program ~~that has one trainee shall have~~ had the trainee work with other doctoral level psychology trainees and ~~shall include~~ included in the written statement required in A.R.S. § 32-2071(D)(9) a description of the program policy specifying the opportunities and resources provided to the trainee for working or interacting with other doctoral level psychology trainees in the same or other sites~~.~~;

~~G.~~ 6. ~~Time~~ That time spent fulfilling academic degree requirements such as course work applied to the doctoral degree, practicum, field laboratory, dissertation, or thesis credit ~~shall not be~~ is not credited toward the 1,500 hours of professional experience hours required by A.R.S. § 32-2071(D). This rule does not restrict a student from participating in

activities designed to fulfill other doctoral degree requirements; however, the Board shall not credit such time ~~shall not be credited~~ toward the hours required by A.R.S. § 32-2071(D); and

~~**H.**~~ 7. ~~To~~ That to satisfy the first 1,500 hours required by A.R.S. § 32-2071(D), the written statement required ~~pursuant to~~ under A.R.S. § 32-2071(D)(9) ~~shall have been~~ was established by the time the student began training. ~~Acquiring~~ The Board shall not accept experience or ~~claiming~~ credit for the past activities ~~shall not be accepted~~ as a training program or a pre-doctoral internship.

R4-26-211. Foreign Graduates

A. ~~Pursuant to~~ Under A.R.S. § 32-2071(B), an applicant for licensure whose application is based on graduation from a foreign institution of higher education shall provide the Board with documents and evidence to establish that the applicant's formal education is equivalent to a doctoral degree in psychology from a regionally accredited institution as described in A.R.S. § 32-2071(A).

B. ~~The~~ An applicant shall provide the following information to the Board:

1. An original and a copy of the doctoral diploma or certificate of graduation. The original shall be returned, and the copy shall be retained by the Board.
2. An official transcript, containing an original university seal or comparable document recording all course work completed.
3. A certified English translation of all documents submitted.
4. Evidence of completion of the requirements of A.R.S. § 32-2071(C)(D) and (E).
5. Evidence that the doctoral dissertation or project was primarily psychological. The Board may require the applicant to submit the doctoral dissertation or project.
6. A statement prepared by the applicant, based upon the documents referred to in this Section, indicating the chronological sequence of studies and research. The format of this statement shall be comparable to a transcript issued by United States universities.

ARTICLE 3. REGULATION

R4-26-303. Titles

~~The use of~~ A person shall not use a designation~~s~~ that claims a potential or future degree or qualification such as "Ph.D. (Cand)~~,"~~," "Ph.D. (ABD)~~,"~~," "License Eligible~~,"~~," "Candidate for Licensure", or "Board Eligible" ~~are not titles that designate trainee status as described in A.R.S. § 32-2071(D)(8), nor do such titles qualify for exemption under A.R.S. § 32-2075(A)(2) or (3)~~. The use of a title~~s~~ that claims a potential or future degree or qualification ~~may be construed by the Board as~~ is a violation~~s~~ of ~~A.R.S. §§ 32-2061(13)(c), 32-2071.01(3), and 32-2084~~ A.R.S. § 32-2061, et seq.

R4-26-308. Rehearing or Review of Decision

A. Except as provided in subsection (G)~~.~~, any party in a contested case before the Board ~~of Psychologist Examiners~~ who is aggrieved by a Board order or decision rendered in such case may file with the Board ~~of Psychologist Examiners~~, not later than ~~ten~~ 30 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds ~~therefor~~ for rehearing or review. For purposes of this subsection, a Board order or decision ~~shall be deemed to have been~~ is served when personally delivered or mailed by certified mail to the party at the party's last known residence or place of business.

B. A motion for rehearing or review may be amended at any time before it is ruled upon by the Board. A response may be filed within ~~ten~~ 15 days after service of such motion or amended motion by any other party. The Board may require written briefs upon the issues raised in the motion and may provide for oral argument. A party who files pleadings or other documents with the Board shall file an original and 11 3-hole punched copies.

C. A rehearing or review of ~~the~~ a Board order or decision may be granted for any of the following causes materially affecting the moving party's rights:

1. An irregularity in the administrative proceedings of the agency, ~~or~~ its hearing officer, or the prevailing party, or any order or abuse of discretion, whereby the moving party was deprived of a fair hearing~~.~~;
2. Misconduct of the Board, ~~or~~ its hearing officer, or the prevailing party~~.~~;
3. An accident or surprise ~~which could not have been~~ that could not be prevented by ordinary prudence~~.~~;
4. Newly discovered material evidence ~~which~~ that could not with reasonable diligence ~~have been~~ be discovered and produced at the original hearing~~.~~;
5. Excessive or insufficient penalties~~.~~;
6. An error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing or during the progress of the case~~.~~; or
7. ~~That the~~ A Board order or decision that is not justified by the evidence or is contrary to law.

D. The Board may affirm or modify ~~the~~ a Board order or decision or grant a rehearing or review to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (C). An order granting a rehearing or review shall specify ~~with particularity~~ the grounds on which the rehearing or review is granted, and the rehearing or review shall cover only those matters so specified.

E. Not later than ~~ten~~ 30 days after a Board order or decision is rendered, the Board may on its own initiative order a rehearing or review of its order or decision for any reason ~~which it might have granted a rehearing on motion of a party~~ specified in subsection (C). After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion. In either case the order granting such a rehearing or review shall specify the grounds ~~therefor~~ for rehearing or review.

F. When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing party may, within ~~ten~~ 15 days after such service, serve opposing affidavits~~,~~. ~~which period may be extended for not more than 20 days by~~ The Board for good cause ~~shown~~ or by written ~~stipulation~~ agreement of ~~the~~ all parties may extend for not more than 20 days the period for service of opposing affidavits. Reply affidavits may be permitted.

G. If ~~in a particular decision~~ the Board ~~makes specific findings~~ finds that the immediate effectiveness of ~~such~~ a Board order or decision is necessary for the immediate preservation of the public peace, health, and safety and that a rehearing or review of the Board order or decision is impracticable, unnecessary, or contrary to the public interest, the Board order or decision may be issued as a final order or decision without an opportunity for a rehearing or review. If a Board order or decision is issued as a final order or decision without an opportunity for rehearing or review, any application for judicial review of the order or decision shall be made within the time permitted for final orders or decisions.

H. For purposes of this Section, ~~the terms~~ "contested case" ~~and "party" shall be~~ is defined as provided in A.R.S. § 41-1001.

I. To the extent that the provisions of this Section are in conflict with the provisions of any statute providing for rehearing or review of orders or decisions of the Board, such statutory provisions shall govern.

Editor's note: In accordance with A.A.C. R1-1-109(D), the following Notice of Final Rulemaking is republished to correct printing errors in the text and replaces Notice of Final Rulemaking: 6 A.A.R. 2948-2952, August 11, 2000.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES - NONCOMMUNICABLE DISEASES

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-4-101	Amend
R9-4-102	Repeal
R9-4-201	Renumber
R9-4-201	New Section
R9-4-202	Renumber
R9-4-202	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. § 36-136(F)

Implementing statute: A.R.S. § 36-606

3. The effective date for the rule:

The rules will become final when approved by the Governor's Regulatory Review Council and filed with the Office of the Secretary of State.

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

Notice of Rulemaking Docket Opening: 5 A.A.R. 4267, November 5, 1999

Notice of Proposed Rulemaking: 6 A.A.R. 1062, March 24, 2000

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

Name: Patricia M. Arreola

Address: Arizona Department of Health Services
Bureau of Epidemiology and Disease Control Services
3815 North Black Canyon Highway
Phoenix, Arizona 85015

Telephone: (602) 230-5943

Fax: (602) 230-5933

E-Mail: parreol@hs.state.az.us

OR

Name: Kathleen Phillips, Rules Administrator

Address: Arizona Department of Health Services
1740 West Adams, Room 102
Phoenix, Arizona 85007

Telephone: (602) 542-1264

Fax: (602) 542-1090

E-Mail: kphilli@hs.state.az.us

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

The Department is amending the general definitions Section for the Chapter to conform to current rulemaking format and style requirements, to define 2 terms previously undefined, and to define a term previously defined elsewhere. In addition, the Department is repealing the definitions Section pertaining specifically to the Pesticide Illness Article and replacing it with a new definitions Section within the Pesticide Illness Article that will provide clearer definitions of the terms used in the Article. The Department is also renumbering and amending the only Section previously in the Pesticide Illness Article, regarding pesticide illness reporting requirements, to conform to current rulemaking format and style requirements and to clarify the rule. The Department is eliminating the requirement to report race or ethnicity, is requiring that occupation be reported only if a documented pesticide exposure is related to the occupation, and is expressly allowing that reporting be done by a designated representative of the health care professional or poison control center medical director. The Department is otherwise not changing the reporting requirements of the rule.

7. A reference to any study that the agency proposes to rely on in its evaluation of or justification for the 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

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

Not applicable

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

The Department expects that this rulemaking will impose no economic burden other than the expense of the rulemaking process to the Department, the Office of the Secretary of State, and the Governor's Regulatory Review Council and the expense to the Department of purchasing 2 copies of ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (5th ed. 2000), which is incorporated by reference in A.A.C. R9-4-101. The Department anticipates that the public will benefit from the clarification of the rules because the rules will be less confusing to apply.

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

R9-4-101

The Department added a definition for the term "diagnosis", which is used in Articles 2, 4, and 5 of Chapter 4 and was previously undefined. As a result, the Department renumbered several other definitions.

The Department changed the citation form in the definition of "hospital" from "A.A.C. Title 9, Chapter 10" to "9 A.A.C. 10", to conform to current rulemaking format and style requirements.

R9-4-201

The Department changed the definition of "cluster illness" to make it more clear, concise, and understandable.

The Department deleted the word "defined" from the definition of "pest" to make it more clear, concise, and understandable.

The Department deleted the word "purposes" from the definition of "pesticide" to make it more clear, concise, and understandable.

The Department changed the word "illness" to "sickness" in the definition of "pesticide illness" and reformatted the definition as a displayed list in order to make it more clear, concise, and understandable.

11. A summary of the principal comments and the agency response to them:

The Department did not receive any comments about the proposed rulemaking.

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

Not applicable

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

A.A.C. R9-4-101: ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (5th ed. 2000).

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

No

15. The full text of the rule follows:

TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES - NONCOMMUNICABLE DISEASES

ARTICLE 1. DEFINITIONS

Sections
R9-4-101. Definitions, general
~~R9-4-102.~~ ~~Pesticide Illness~~ Repealed

ARTICLE 2. PESTICIDE ILLNESS

Sections
R9-4-201. Definitions
~~R9-4-201.~~ R9-4-202. Pesticide Illness Reporting Requirements

ARTICLE 1. DEFINITIONS

R9-4-101. Definitions, general

In this Chapter, unless ~~the context~~ otherwise ~~requires~~ specified:

1. "Dentist" means ~~any person~~ an individual licensed under ~~the provisions of~~ A.R.S. Title 32, Chapter 11, Article 2.
2. "Department" means the Arizona Department of Health Services.
3. "Diagnosis" means the identification of a disease or injury, by an individual authorized by law to make the identification, that is the cause of an individual's current medical condition.
~~2~~4. "Hospital" means a health care institution licensed by the Department as a general hospital, a rural general hospital, or a special hospital under 9 A.A.C. ~~Title 9, Chapter~~ 10.
5. "ICD-9-CM" means ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification (5th ed. 2000), incorporated by reference, on file with the Department and the Office of the Secretary of State, and available from Practice Management Information Corporation, 4727 Wilshire Boulevard, Suite 300, Los Angeles, CA 90010 and from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. This incorporation by reference contains no future editions or amendments.
~~3~~6. "Physician" means ~~any person~~ an individual licensed as a doctor of allopathic medicine under ~~provisions of~~ A.R.S. Title 32, Chapter 13 or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.

~~R9-4-102.~~ ~~Pesticide Illness~~ Repealed

~~In Article 2, unless the context otherwise requires:~~

~~1.~~ ~~"Case" means any person with an illness which has been determined by a health care professional to be a result of exposure to a pesticide, on the basis of patient history, signs, symptoms or presentation of illness, laboratory findings or results of treatment.~~
~~2.~~ ~~"Cluster illnesses" means two or more cases or suspect cases of pesticide illness which are or may be related.~~
~~3.~~ ~~"Documented" means supported by written information, such as applicator reports, patient statements, or medical records.~~
~~4.~~ ~~"Health care professional" means any physician, hospital intern or resident, surgeon, dentist, osteopath, chiropractor, podiatrist, county medical examiner, nurse or other professional having responsibility for the diagnosis, care or treatment of human illness.~~

~~5. "Pest" means any of the following organisms under circumstances that make it deleterious to man or the environment:~~
   ~~a. Any vertebrate animal other than man;~~
   ~~b. Any invertebrate animal, including any insect, other arthropod, nematode, or mollusk such as a slug and snail, but excluding any internal parasite of living man or other living animals;~~
   ~~c. Any plant growing where not wanted, including moss, alga, liverwort, or other plant of any higher order, and any plant part; or~~
   ~~d. Any fungus, bacterium, virus, or other microorganism, except for those on or in living man or other living animals and those on or in processed food or processed animal feed, beverages, drugs and cosmetics.~~
~~6. "Pesticide" means any substance or mixture of substances, including inert ingredients, intended for preventing, destroying, repelling or mitigating any pests, or any substance or mixture of substances intended for use as a plant growth regulator, defoliant or desiccant.~~
~~7. "Pesticide illness" means disturbance of function, damage to structure or illness in humans which results from the inhalation, absorption or ingestion of any pesticide.~~
~~8. "Poison control centers" means entities in the Arizona poison control network which engage in consultations concerning possible pesticide poisonings.~~
~~9. "Suspect case" means any person with a syndrome or signs and symptoms of illness which a health care professional believes, based on professional judgement, may be a result of exposure to one or more pesticides, but which does not meet the definition of case.~~

ARTICLE 2. PESTICIDE ILLNESS

R9-4-201. Definitions

In this Article, unless otherwise specified:

1. "Cluster illness" means sickness in 2 or more individuals that is caused by or may be related to 1 pesticide exposure incident, as determined by the history, signs, or symptoms of the sickness; laboratory findings regarding the individuals; the individuals' responses to treatment for the sickness; or the geographic proximity of the individuals.
2. "Documented" means evidenced by written information such as pesticide applicator reports, statements of individuals with pesticide illness, or medical records.
3. "Health care professional" means a physician, a registered nurse practitioner, a physician assistant, or any other individual who is authorized by law to diagnose human illness.
4. "Medical director" means the individual designated by a poison control center as responsible for providing medical direction for the poison control center or for approving and coordinating the activities of the individuals who provide medical direction for the poison control center.
5. "Pest" has the same meaning as in A.R.S. Title 3, Chapter 2, Article 5 or as used in A.R.S. Title 3, Chapter 2, Article 6 and A.R.S. Title 32, Chapter 22.
6. "Pesticide" means any substance or mixture of substances, including inert ingredients, intended for preventing, destroying, repelling, or mitigating any pest or intended for use as a plant regulator, defoliant, or desiccant, but does not include an antimicrobial agent, such as a disinfectant, sanitizer, or deodorizer, used for cleaning.
7. "Pesticide illness" means any sickness reasonably believed by a health care professional or medical director to be caused by or related to documented exposure to any pesticide, based upon professional judgment and:
   a. The history, signs, or symptoms of the sickness;
   b. Laboratory findings regarding the individual; or
   c. The individual's response to treatment for the sickness.
8. "Physician assistant" has the same meaning as in A.R.S. § 32-2501.
9. "Poison control center" means an organization that is a member of and may be certified by the American Association of Poison Control Centers.
10. "Registered nurse practitioner" has the same meaning as in A.R.S. § 32-1601.

~~R9-4-201~~ R9-4-202. Pesticide Illness Reporting Requirements

~~Any~~ A health care professional or ~~poison control center, who~~ medical director who participates in the diagnosis of or identifies ~~a case of~~ an individual with pesticide illness~~, or determines that an illness may be related to documented exposure to a pesticide,~~ shall file a report of pesticide illness with the Department as follows:

1. ~~Reports of cases and suspect cases of pesticide illness shall be made~~ The health care professional or medical director shall report a pesticide illness within ~~five~~ 5 working days ~~of~~ from the date of ~~determining that an illness is or may be a result of documented exposure to a pesticide~~ diagnosis or identification, except:
   a. ~~Any case or suspect case which results in hospitalization or death shall be filed immediately or~~ The health care professional or medical director shall report a pesticide illness where the individual with pesticide illness is hospitalized or dies no later than ~~24 hours~~ 1 working day from the time of hospital admission or death~~.~~; and

b. ~~Reports of cluster illnesses shall be filed immediately or~~ The health care professional or medical director shall report cluster illnesses no later than ~~24 hours~~ 1 working day from the time the ~~second case or suspected case~~ 2nd individual with pesticide illness is diagnosed or identified.

2. ~~Reports shall be made~~ The health care professional or medical director shall submit the report to the Department by telephone~~,~~; in person; ~~or~~ in a writing sent by fax, delivery service, or mail; or by an electronic reporting system if an electronic reporting system is developed by the Department. The report shall contain the following information:
   a. ~~Patient's~~ The name, address, and telephone number of the individual with pesticide illness;
   b. ~~Date~~ The date of birth of the individual with pesticide illness;
   ~~c.~~ ~~Race or ethnicity;~~
   ~~d~~c. ~~Gender~~ The gender of the individual with pesticide illness;
   ~~e~~d. ~~Occupation~~ The occupation of the individual with pesticide illness, if the documented pesticide exposure is related to the occupation;
   ~~f~~e. ~~Dates~~ The dates of onset of illness and of diagnosis or identification as pesticide illness;
   ~~g~~f. ~~Name~~ The name of the pesticide, if known;
   ~~h.~~g. ~~Name~~ The name, business address, and telephone number of the ~~person~~ health care professional or medical director making the report;
   h. A statement specifying whether the illness is caused by a documented pesticide exposure or is related to a documented pesticide exposure; and
   i. The health care professional's or medical director's reason for believing that the illness is caused by or related to documented exposure to a pesticide.
   ~~j.~~ ~~Statement specifying whether the illness is caused by or related to a documented pesticide exposure.~~

3. The health care professional or medical director may designate a representative to make the report to the Department on behalf of the health care professional or medical director.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected / Rulemaking Action

Sections Affected	Rulemaking Action
R9-22-101	Amend
R9-22-108	Amend
Article 8	Amend
R9-22-801	Amend
R9-22-802	Repeal
R9-22-802	New Section
R9-22-803	Amend
R9-22-804	Repeal
R9-22-804	New Section
Exhibit A	New Exhibit
R9-22-1208	Amend
Article 13	Amend
R9-22-1301	Amend
R9-22-1302	Amend
R9-22-1303	Amend
R9-22-1304	Amend
R9-22-1305	Amend
R9-22-1307	Amend
R9-22-1308	Amend
R9-22-1309	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. § 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903.01 and 41-1092.02 et. seq.

3. The effective date of the rules:

August 7, 2000

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 658, February 11, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 1348, April 14, 2000

5. 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, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

A. AHCCCS amended 4 Articles in 9 A.A.C. 22, to comply with changes to state statute. The changes were implemented on July 1, 1999, when the AHCCCS administrative hearing process was moved from AHCCCS to the Office of Administrative Hearings (OAH).

B. Most of the remaining changes were made to reduce the ambiguity, improve the clarity, and use consistent terminology in rule language. The most significant change was to remove language in R9-22-802, which allowed for extended benefits beyond the end of the current certification period when a MI/MN (state-funded) member appeals a denial of an eligibility redetermination. The rule was modified so that a member who requests a hearing regarding a denial of a redetermination shall not continue to be AHCCCS-eligible after the end of the certification period. This change is made to be consistent with statute and to be consistent with rules applicable to discontinuances.

C. Several changes were made throughout the Article to make the rules consistent with OAH statute and rule.

  i. "Appeal" was replaced with "request for hearing". This was done because "hearing" now has the meaning defined in the OAH statute at A.R.S. § 41-1092 et seq.

  ii. Time-frames were modified to comply with OAH statute and rule.

  iii. Whenever appropriate, language was cross-referenced to OAH statute or rule.

D. The Administration added Exhibit A in 9 A.A.C. 22, Article 8 to illustrate the grievance and request for hearing process.

7. Reference to any study that the agency relied on in its evaluation of or justification for the 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

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

Not applicable

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

The following entities will be impacted by the changes to the rule language:

i. AHCCCS and the Office of Administrative Hearings (OAH) will benefit from the changes, which clarify their roles in the grievance and request for hearing process. In addition, the state may reduce expenditures as a result of a change to R9-22-804 under which a member who requests a hearing regarding a denial of a redetermination shall not continue to be AHCCCS-eligible after the end of the certification period. This change is made to be consistent with statute and other AHCCCS rules.

ii. MI/MN (state-funded) members who request a hearing regarding a denial of an additional period of eligibility, will no longer have AHCCCS coverage after the end of their certification period pending the outcome of the hearing. These individuals will be responsible to pay for health care costs they incur after the end of their certification period. However, if the hearing decision is in favor of the member, AHCCCS will continue to retroactively cover AHCCCS covered services.

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

#	Subsection	Recommendation
1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.
2.	Preamble, Notice of Proposed Rulemaking	The Administration amended the language to clarify that it is the MN/MI member's responsibility to pay for health care costs they incur after the end of their certification period. However, if the hearing decision is in favor of the member, AHCCCS will continue to retroactively cover AHCCCS covered services.
3.	R9-22-101	The Administration added a definition of "Director" to clarify that Director means the Director of the Administration or the Director's designee and to make the rules more clear, concise, and understandable.
4.	R9-22-108	The Administration added "entity" to the definition of "complainant" to clarify that contractors may be complainants.
5.	R9-22-108	The Administration added a definition of "party" to make the rules more clear, concise, and understandable.
6.	R9-22-801(D)(2)	The Administration amended the language to clarify that nonprivileged documents are those that are not protected from disclosure by law.
7.	R9-22-801(E)	The Administration clarified that a request for hearing regarding a policy may be denied because it is not subject to OAH's jurisdiction under A.R.S. § 41-1092.
8.	R9-22-801(F)(1)	The Administration amended the language to clarify that the Director may grant a motion for rehearing or review if good cause for not appearing at a hearing is established. The Administration deleted the language regarding the actions that the Director may take on a motion for rehearing or review because these are in A.R.S. § 41-1092.09.
9.	R9-22-802	The Administration reorganized the Section to make the language more clear, concise, and easy to understand.
10.	R9-22-802	The Administration corrected the statutory references to A.R.S. § 36-2903.01 by replacing them with references to A.R.S. § 36-2904 because the anticipated statutory change did not pass.
11.	R9-22-802	The Administration added language to clarify that a complainant may request a hearing if the Administration fails or refuses to decide a grievance within 30 days.
12.	R9-22-802 R9-22-803 R9-22-804	The Administration changed the 35-day time-frames for filing a request for hearing to be consistent with the 30-day requirement in OAH statute.
13.	R9-22-803 R9-22-804	The Administration amended the language to clarify that the Administration will issue a notice of hearing if the Administration receives a timely request for hearing.
14.	R9-22-804(C)(5) R9-22-804(E)(1)	The Administration amended the language to make it more clear.
15.	Exhibit A	The Administration amended the Exhibit under grievances to contractors and grievance to AHCCCS to read only "Grievance for claim denial filed 12 months from date of service. A.R.S. § 36-2904" because the anticipated change to A.R.S. § 36-2903.01 did not pass. The Administration amended the language in the Exhibit to correspond with changes made throughout the rules.
16.	Exhibit A	The Administration amended the language in the Exhibit to correspond with changes made throughout the rules.
17.	Exhibit A R9-22-802	The Administration amended the rules to require the Administration to issue a decision no later than 30 days after receipt of the grievance or request for hearing unless the complainant agrees to an extension.

18.	R9-22-1301 (B)	The Administration amended the language to clarify that "Action" means a denial, termination, suspension, or reduction of a service, rather than a "covered" service.
19.	R9-22-1304	The Administration amended the language regarding the reasons and authority for an action to ensure that a member has sufficient information to understand why a service is being denied or reduced.
20.	R9-22-1307 (A)	The Administration made several structural changes to this Section to make the language more clear, concise, and easy to understand: 1. Moved R9-22-1307(A) to the new subsection R9-22-1307(H); and 2. Moved part of R9-22-1307(B) to R9-22-1307(A).
21.	R9-22-1307	The Administration reorganized the language to make it more clear, concise, and understandable. The Administration amended the language to clarify that a member may file a request for hearing with the Administration or a contractor.
22.	R9-22-1307	The Administration amended the language to clarify that if a member requests an expedited hearing and requests continued services, a contractor shall not terminate, reduce, or suspend the service during the expedited hearing process.
23.	R9-22-1307	The Administration amended the language to clarify that a member must request continued services and to be consistent with other rules that require the member to request continued services.

11. A summary of the principal comments and the agency response to them:

The Administration conducted a videoconference public hearing in Phoenix, Flagstaff, and Tucson, Arizona and an additional public hearing in Casa Grande, Arizona on May 16 and 17, 2000. No one attended either public hearing.

Before the close of record, 5:00 p.m., Wednesday, May 17, 2000, the Administration received written comments from the Department of Economic Security, Phoenix Health Plan, and Coconino County. The Administration conducted conference calls with each person or entity that submitted written comments to discuss the Administration's response to each comment.

The Department of Economic Security commented that "Exhibit A clearly outlines the grievance and hearing procedures, the appropriate time-frames associated with specific types of grievances, the requirements necessary to receive continued coverage, and the process as it involves the Office of Administrative Hearings. In addition, the references linking Exhibit A to the rules document were easy to follow and well-labeled."

Phoenix Health Plan commented that the proposed rules were "streamlined," "more clear and concise," and that time-frames were "standardized so they are more consistent." Phoenix Health Plan also commented that Exhibit A was an "excellent idea" and "a good view of the process." Phoenix Health Plan had several questions regarding expedited hearings in 9 A.A.C. 22, Article 13. The Administration responded by amending the definition of "Action" to clarify that a member may file a grievance regarding the denial of a noncovered service. The Administration also amended the language to clarify that if a member requests an expedited hearing and continued services, a contractor must continue services at the same level in effect on the date the contractor issues the notice. Phoenix Health Plan had additional comments about exceptions from advance notice in R9-22-1305 and grievance time-frames in R9-22-802. The Administration responded to those questions in discussions with Phoenix Health Plan that clarified their concerns.

The Administration amended the language to clarify that "nonprivileged documents" refers to those which are "not protected from disclosure by law" in response to a comment from Coconino County. In response to another comment from Coconino County, the Administration amended the language regarding the effective date of eligibility in R9-22-804 to make it more clear, concise, and easy to understand.

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

Not applicable

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

None

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Sections
R9-22-101. Location of Definitions
R9-22-108. Grievance and ~~Appeal Process~~ Request for Hearing Related Definitions

ARTICLE 8. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

Sections
R9-22-801. General Provisions ~~For All Grievances and Appeals~~ for a Grievance and a Request for Hearing
~~R9-22-802. Eligibility Appeals For Applicants, Eligible Persons and Members Receiving State-funded AHCCCS Services~~
R9-22-802. Grievance
R9-22-803. Eligibility ~~Appeals for Applicants, Eligible Persons, and Members Receiving SSI-Related Medical Assistance Only AHCCCS Services~~ Hearing for an Applicant and a Member Under R9-22-1435, 9 A.A.C. 22, Article 15, and R9-22-1704
~~R9-22-804. Grievances~~
R9-22-804. Eligibility Hearing for an Applicant and a Member Under 9 A.A.C. 22, Article 16
Exhibit A. Grievance and Request for Hearing Process

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section
R9-22-1208. Grievance and ~~Appeal~~ Request for Hearing Process

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

Sections
R9-22-1301. General Intent and Definitions
R9-22-1302. Denial of a Request for a Service
R9-22-1303. Reduction, Suspension, or Termination of a Service
R9-22-1304. Content of Notice
R9-22-1305. Exceptions from an Advance Notice
R9-22-1307. Expedited Hearing Process
R9-22-1308. Maintenance of Records
R9-22-1309. Member Handbook

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
"210"	R9-22-114
"1931"	R9-22-114
"1-time income"	R9-22-116
"1st-party liability"	R9-22-110
"3-month income period"	R9-22-116
"3rd-party"	R9-22-110
"3rd-party liability"	R9-22-110
"Accommodation"	R9-22-107
"Act"	R9-22-114
"Acute mental health services"	R9-22-112
"Adequate notice"	R9-22-114
"ADHS"	R9-22-112
"Administration"	A.R.S. § 36-2901
"Administrative law judge"	R9-22-108
"Administrative review"	R9-22-108
"Adverse action"	R9-22-114
"AEC"	R9-22-117
"Affiliated corporate organization"	R9-22-106

“Aged” 42 U.S.C. 1382c(a)(1)(A)
“Aggregate” R9-22-107
“AHCCCS” R9-22-101
“AHCCCS-disqualified dependent” R9-22-101
“AHCCCS-disqualified spouse” R9-22-101
~~“AHCCCS hearing officer”~~ ~~R9-22-108~~
“AHCCCS inpatient hospital day or days of care” R9-22-107
“Ambulance” R9-22-102
“Ancillary department” R9-22-107
“Annual enrollment choice” R9-22-117
~~“Appeal”~~ ~~R9-22-108~~
“Appellant” R9-22-114
“Applicant” R9-22-101
“Application” R9-22-101
“Assignment” R9-22-101
“Assistance unit” R9-22-114
“Authorized representative” R9-22-114
“Auto-assignment algorithm” R9-22-117
“Baby Arizona” R9-22-114
“Behavior management services” R9-22-112
“Behavioral health paraprofessional” R9-22-112
“Behavioral health professional” R9-22-112
“Behavioral health service” R9-22-112
“Behavioral health technician” R9-22-112
“BHS” R9-22-114
“Billed charges” R9-22-107
“Blind” R9-22-115
“Board-eligible for psychiatry” R9-22-112
“Bona fide funeral agreement” R9-22-114
“Burial plot” R9-22-114
“Capital costs” R9-22-107
“Capped fee-for-service” R9-22-101
“Caretaker relative” R9-22-114
“Case management services” R9-22-112
“Case record” R9-22-101
“Cash assistance” R9-22-114
~~“Categorically eligible”~~ <u>“Categorically-eligible”</u> A.R.S. §§ 36-2901 and 36-2934
“Certification” R9-22-109
“Certification error” R9-22-109
“Certification period” R9-22-115 and R9-22-116
“Certified psychiatric nurse practitioner” R9-22-112
“Clean claim” A.R.S. § 36-2904
“Clinical supervision” R9-22-112
“CMDP” R9-22-117
<u>“Complainant“</u> <u>R9-22-108</u>
“Continuous stay” R9-22-101
“Contract” R9-22-101
“Contractor“ R9-22-101
“Contractor of record” R9-22-101
“Copayment” R9-22-107
“Corrective action plan” R9-22-109
“Cost-to-charge ratio” R9-22-107
“Countable income” R9-22-116
“County eligibility department” R9-22-109
“County eligibility staff” R9-22-116
“Covered charges” R9-22-107
“Covered services” R9-22-102
“CPT” R9-22-107
“CRS” R9-22-114

“Date of determination” R9-22-116
“Date of enrollment action” R9-22-117
“Date of notice” R9-22-108
“Day” R9-22-101
“DCSE” R9-22-114
“Deductible medical expense” R9-22-116
“Deemed application date” R9-22-116
“De novo hearing” R9-22-112
“Dentures” R9-22-102
“Department” R9-22-114
“Dependent child” R9-22-114 and R9-22-116
“DES” R9-22-101
“Determination” R9-22-116
“Diagnostic services” R9-22-102
“Director” R9-22-101
“Disabled” R9-22-115
“Discontinuance” R9-22-116
“Discussions” R9-22-106
“Disenrollment” R9-22-117
“District Medical Consultant” R9-22-114
“DME” R9-22-102
“DRI inflation factor” R9-22-107
“E.P.S.D.T. services” R9-22-102
“EAC” R9-22-101
“Earned income” R9-22-116
“Educational income” R9-22-116
“ELIC” R9-22-101
“Eligible person” A.R.S. § 36-2901
“Emancipated minor” R9-22-116
“Emergency medical condition” 42 U.S.C. 1396b(v)
“Emergency medical services” R9-22-102
“Encounter” R9-22-107
“Enrollment” R9-22-117
“Enumeration” R9-22-101
“Equity” R9-22-101
“Evaluation” R9-22-112
“Expressly emancipated minor” R9-22-116
“FAA” R9-22-114
“Facility” R9-22-101
“Factor” R9-22-101
“FBR” R9-22-101
“FESP” R9-22-101
“Foster care maintenance payment” 41 U.S.C. 675(4)(A)
“FPL” R9-22-114
“FQHC” R9-22-101
“Fraudulent information” R9-22-109
“Grievance” R9-22-108
“GSA” R9-22-101
“Guardian” R9-22-116
“Head-of-household” R9-22-116
“Hearing” R9-22-108
“Hearing aid” R9-22-102
“Home health services” R9-22-102
“Homebound” R9-22-114
“Hospital” R9-22-101
“Hospitalized” R9-22-116
“ICU” R9-22-107
“IHS” R9-22-117
“IMD” R9-22-112

"Income"	R9-22-114 and R9-22-116
"Income-in-kind"	R9-22-116
"Indigent"	A.R.S. § 11-297
"Inmate of a public institution"	42 CFR 435.1009
"Inpatient psychiatric facilities for persons under age 21"	R9-22-112
"Interested party"	R9-22-106
"Interim change"	R9-22-116
"JTPA"	R9-22-114
"License" or "licensure"	R9-22-101
"Liquid resources"	R9-22-116
"Lump-sum income"	R9-22-116
"Mailing date"	R9-22-114
"Medical education costs"	R9-22-107
"Medical record"	R9-22-101
"Medical review"	R9-22-107
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medical support"	R9-22-114
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-107
"Medicare HMO"	R9-22-101
"Member"	R9-22-101
"Mental disorder"	R9-22-112
"MI/MN"	A.R.S. § 36-2901(4)(a) and (c)
"Minor parent"	R9-22-114
"Month of determination"	R9-22-116
"New hospital"	R9-22-107
"NF"	R9-22-101
"NICU"	R9-22-107
"Noncontracting provider"	A.R.S. § 36-2931
"Nonliquid resources"	R9-22-116
"Nonparent caretaker relative"	R9-22-114
<u>"OAH"</u>	<u>R9-22-108</u>
"Occupational therapy"	R9-22-102
"Offeror"	R9-22-106
"Operating costs"	R9-22-107
"Outlier"	R9-22-107
"Outpatient hospital service"	R9-22-107
"Ownership change"	R9-22-107
"Partial Care"	R9-22-112
<u>"Party"</u>	<u>R9-22-108</u>
"Peer group"	R9-22-107
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Pre-enrollment process"	R9-22-114
"Prescription"	R9-22-102
"Primary care provider"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Private duty nursing services"	R9-22-102
"Proposal"	R9-22-106
"Prospective rates"	R9-22-107
"Prospective rate year"	R9-22-107
"Prudent layperson standard"	42 U.S.C. 1396u-2
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112

“Psychosocial rehabilitation” R9-22-112
“Public assistance” R9-22-116
“Quality control case analysis” R9-22-109
“Quality control sample review” R9-22-109
“Quality management” R9-22-105
“Radiology services” R9-22-102
“RBHA” R9-22-112
“Rebasing” R9-22-107
“Recipient” R9-22-114
“Redetermination” R9-22-116
“Referral” R9-22-101
“Rehabilitation services” R9-22-102
“Reinsurance” R9-22-107
“Resources” R9-22-114 and R9-22-116
“Respiratory therapy” R9-22-102
“Respondent” R9-22-108
“Responsible offeror” R9-22-106
“Responsive offeror” R9-22-106
“Review” R9-22-114
“RFP” R9-22-106
“Scope of services” R9-22-102
“Screening” R9-22-112
“SDAD” R9-22-107
“Separate property” A.R.S. § 25-213
“Service location” R9-22-101
“Service site” R9-22-101
“SESP” R9-22-101
“S.O.B.R.A.” R9-22-101
“Specialist” R9-22-102
“Specified relative” R9-22-114 and R9-22-116
“Speech therapy” R9-22-102
“Spendthrift restriction” R9-22-114
“Spouse” R9-22-101
“SSA” P.L. 103-296, Title I
“SSI” R9-22-101
“SSN” R9-22-101
“State alien” R9-22-101
“Sterilization” R9-22-102
“Subcontract” R9-22-101
“Substance abuse” R9-22-112
“SVES” R9-22-114
“Tier” R9-22-107
“Tiered per diem” R9-22-107
“Title IV-A” R9-22-114
“Title IV-D” R9-22-114
“Title IV-E” R9-22-114
“Title XIX” 42 U.S.C. 1396
“Title XXI” 42 U.S.C. 1397jj
“TMA” R9-22-114
“Total inpatient hospital days” R9-22-107
“Treatment” R9-22-112
“Unearned income” R9-22-116
“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:

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

“AHCCCS-disqualified dependent” means a dependent child of an AHCCCS-disqualified spouse who resides in the same household of an AHCCCS-disqualified spouse.

"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.

"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.

"Application" means an official request for medical assistance made under this Chapter.

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

"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 a member. A payment is made in accordance with an upper, or capped, limit established by the Director.

"Case record" means the file and all documents in the file that are used to establish eligibility.

~~"Categorically eligible"~~ "Categorically-eligible" means a person who is eligible as defined by A.R.S. §§ 36-2901 and 36-2934.

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

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

"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.

"Contractor of record" means an organization or an entity in which a person is enrolled for the provision of AHCCCS services.

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

"Director" means the Director of the Administration or the Director's designee.

"DES" means the Department of Economic Security.

"EAC" means eligible assistance children defined by A.R.S. § 36-2905.03.

"ELIC" means eligible low-income children defined by A.R.S. § 36-2905.03.

"Eligible person" means the person defined in A.R.S. § 36-2901

"Enumeration" means the assignment of a specific 9-digit identification number to a person by the Social Security Administration.

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

"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.

"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.

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

"FESP" means federal emergency services program that 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~~ categorically-eligible member who is determined eligible under A.R.S. § 36-2903.03.

"FQHC" means federally qualified health center.

"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.

"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.

"Indigent" means meeting eligibility criteria under A.R.S. § 11-297.

"Inmate of a public institution" means a person defined by 42 CFR 435.1009.

"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.

"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.

"Medical services" means health care services provided to a member 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.

"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.

"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).

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

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

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

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

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

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

"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.

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

"SESP" means state emergency services program that 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.

"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.

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

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

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

"SSN" means social security number.

"State alien" means a nonqualified alien under A.R.S. § 36-2903.03 who:

a. Was residing in the United States under color of law on or before August 21, 1996;
b. Was receiving AHCCCS services under SSI eligibility criteria; and
c. Would be eligible for coverage under 9 A.A.C. Article 15 except for United States citizenship or legal alienage requirements.

"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.

R9-22-108. Grievance and ~~Appeal Process~~ Request for Hearing 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.~~ ~~"AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.~~

~~2.~~ ~~"Appeal" means a review process initiated in accordance with Article 8.~~

"Administrative law judge" means the person defined in A.R.S. § 41-1092.

"Administrative review" means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et seq.

"Complainant" means an applicant, member, person, or entity filing a grievance or request for hearing.

"Date of notice" means the date on a notice of action.

~~3.~~ "Grievance" means a complaint ~~initiated in accordance with Article 8.~~ that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et. seq. A party may request a hearing under A.R.S. § 41-1092 et. seq. after an administrative review.

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

"OAH" means the Office of Administrative Hearings defined in A.R.S. § 41-1092 et. seq.

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

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

ARTICLE 8. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

R9-22-801. General Provisions ~~For All Grievances and Appeals~~ for a Grievance and a Request for Hearing

A. Definitions. In this ~~Article:~~ Article, "Adverse action" means any action under this Chapter for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et. seq., under this Article.
   ~~1. "Appellant" means an individual filing any grievance or appeal under this Article.~~
   ~~2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the Administration; an appeal of a grievance decision rendered by a contractor; or an appeal filed because a contractor has failed to render a timely grievance decision.~~
   ~~3. "Respondent" means the party responsible for the action being grieved or appealed. In eligibility appeals regarding state-funded services, the county is the respondent. In eligibility appeals regarding SSI-related medical assistance only services, the Administration is the respondent. In most member grievances, the contractor generally is the respondent.~~

B. Filing ~~grievances and appeals.~~ a grievance and a request for hearing. Unless provided elsewhere in this Chapter, ~~all grievances and appeals~~ a written grievance or a request for hearing under A.R.S. § 41-1092 et. seq., or other written statements shall be considered filed when received ~~in writing~~ by the ~~Administration.~~ Administration, as established by the Office of Legal Assistance's date stamp on the grievance, request for hearing or other written statement.

C. Computation of time.
   1. ~~In computing any period of time for establishing timeliness of~~ Computation of time for filing ~~grievances and appeals, the period shall commence~~ a grievance begins the day after the act, event, or decision grieved ~~or appealed,~~ and ~~shall include~~ includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period ~~shall be~~ is extended until the end of the next day that is not a weekend or a legal holiday.
   2. Timeliness for filing a request for hearing under A.R.S. § 41-1092 et. seq. is computed under R2-19-107.
   3. The 30-day time-frame for filing a request for hearing under A.R.S. § 41-1092 et. seq. begins with the date that the notice of adverse action is dated.

D. ~~Appellant's~~ Complainant's hearing rights. The Administration shall ~~afford an appellant~~ allow a complainant the right to:
   1. ~~Have a~~ A hearing ~~that is conducted as specified in A.R.S. §§ 41-1061 and 41-1062.~~ under A.R.S. § 41-1092 et. seq.; and
   2. ~~Obtain copies~~ Copies of any relevant document from the respondent not protected from disclosure by law ~~or from AHCCCS~~ at the ~~appellant's~~ complainant's expense.
   ~~3. Appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the Administration a written statement that is signed and notarized prior to the hearing.~~
   ~~4. Bring an interpreter to assist at the hearing.~~
   ~~5. Be provided an interpreter by the Administration if hearing-challenged according to A.R.S. § 12-242.~~

E. Withdrawal or denial of a request for hearing.
   1. Withdrawal of a request for hearing.
      a. The ~~AHCCCS Chief Hearing Officer or designee~~ Administration shall ~~deny a request for hearing and deny a grievance or appeal~~ accept a written request for withdrawal if ~~a~~ the written request for withdrawal is received from the ~~appellant~~ complainant before ~~the date of the hearing. The case file then shall be closed.~~ the Administration issues a notice of hearing under A.R.S. § 41-1092 et. seq.
      b. If the Administration issued a notice of hearing under A.R.S. § 41-1092 et. seq., a complainant shall send a request for withdrawal to OAH.
   2. Denial of a request for hearing. The ~~AHCCCS Chief Hearing Officer or designee~~ Administration may deny a request for hearing under A.R.S. § 41-1092 et. seq. ~~and dismiss a grievance or appeal~~ upon written determination that:
      a. The request for hearing is untimely;
      b. The request for ~~hearing, grievance, or appeal~~ hearing is not for ~~a reason~~ an adverse action permitted under this Article;
      c. ~~The appellant's appeal rights have been waived under Article 3; or~~ The complainant waives the right to a hearing;
      d. The ~~appeal~~ request for hearing is ~~otherwise moot.~~ moot, as determined by the Administration based on the factual circumstances of each case;
      e. The subject matter of the grievance is a policy that is not subject to OAH's jurisdiction under A.R.S. § 41-1092 et. seq.; or
      f. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all applicants or members.

~~**F.** Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include the following information:~~
   ~~1. A statement asserting the appellant's financial liability if AHCCCS benefits are continued during an eligibility appeal and a proposed discontinuance or redetermination denial is upheld by the Director, and~~

~~2. A statement informing an appellant how to request a change in the scheduled hearing date.~~

~~G. Postponement.~~

~~1. The AHCCCS Chief Hearing Officer or designee on the officer or designee's own motion may postpone a hearing. When a request for postponement is made, it shall be in writing and received by the Administration, Office of Grievance and Appeals, no later than 5 days before the scheduled hearing date. The AHCCCS Chief Hearing Officer or designee may grant a request for postponement on a showing that:~~

~~a. There is substantial cause for the postponement, and~~

~~b. The cause is beyond the reasonable control of the party making the request.~~

~~2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.~~

~~H. Failure to appear for hearing. If any party or representative fails to appear at a hearing without good cause or a postponement, the AHCCCS Chief Hearing Officer or designee may:~~

~~1. Proceed with the hearing,~~

~~2. Reschedule the hearing with further notice,~~

~~3. Issue a decision based on the evidence of record, or~~

~~4. Issue a default disposition.~~

~~I. Conduct of hearing. The hearing shall be conducted as specified in to A.R.S. §§ 41-1061 and 41-1062.~~

~~1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.~~

~~2. The AHCCCS Chief Hearing Officer or designee may:~~

~~a. Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;~~

~~b. Require parties to state their positions concerning the various issues in the proceeding;~~

~~c. Require parties to produce for examination those relevant witnesses and documents under their control;~~

~~d. Rule on motions and other procedural items;~~

~~e. Regulate the course of the hearing and conduct of participants;~~

~~f. Establish time limits for submission of motions or memoranda;~~

~~g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:~~

~~i. Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;~~

~~ii. Excluding all testimony of an unresponsive or evasive witness; and/or~~

~~iii. Expelling the individual from further participation in the hearing;~~

~~h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matters of judicial notice; and~~

~~i. Administer oaths or affirmations.~~

~~J. AHCCCS Hearing Officer recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the AHCCCS Hearing Officer shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.~~

~~K. Decision of the Director.~~

~~1. The Director may affirm, modify, or reject the Hearing Officer's recommendation in whole or in part; may remand a matter to any party or the Hearing Officer with specific instructions; or make any other appropriate disposition.~~

~~2. The Director shall mail by certified mail a copy of the decision to all parties at the last known residence or place of business of each party.~~

~~3. If a discontinuance or denial of AHCCCS eligibility is upheld, the decision also shall state that the appellant may reapply for AHCCCS benefits under the conditions specified in Article 3.~~

~~L.~~**F.** ~~Petition~~ Motion for rehearing or review.

~~1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:~~ Under A.R.S. § 41-1092.09, the Director may grant a rehearing or review for any of the following reasons materially affecting a party's rights:

~~a.~~1. Irregularity in the proceedings of ~~the~~ a hearing ~~or appeal whereby the~~ that ~~aggrieved party was~~ deprived an aggrieved party of a fair ~~hearing or appeal;~~ hearing;

~~b.~~2. Misconduct of ~~a party or the agency;~~ the Administration, OAH, or a party;

~~c.~~3. Newly discovered material evidence, ~~which~~ that could not, with reasonable ~~diligence could not~~ diligence, have been discovered and produced at the hearing;

~~d.~~4. ~~That the~~ The decision is the result of passion or prejudice; ~~or~~

~~e.~~5. ~~That the~~ The decision is not justified by the evidence or is contrary to ~~law.~~ law; or

6. Good cause is established for the nonappearance of a party at the hearing.

~~2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party also shall send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the final administrative decision is the decision the Director renders as a result of the petition.~~

~~3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.~~

~~4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the Hearing Officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.~~

~~5. The Director, within the time for filing a petition for rehearing or review, may on the Director's own motion order a rehearing or issue an amended decision for any reason for which the Director might have done so upon petition of a party.~~

~~**M.** Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.~~

G. Right to reapply. If a discontinuance or denial of eligibility is upheld under A.R.S. § 41-1092.08, the decision shall state that a complainant may reapply for AHCCCS eligibility.

~~R9-22-802. Eligibility Appeals For Applicants, Eligible Persons and Members Receiving State-funded AHCCCS Services~~ Repealed

~~**A.** Adverse eligibility actions. An applicant, eligible person, or member receiving state-funded AHCCCS services may appeal and request a hearing concerning any of the following adverse eligibility actions:~~

~~1. Denial of eligibility,~~

~~2. Discontinuance of eligibility, or~~

~~3. Delay in the eligibility determination beyond 30 days from the date of application unless the head of household agrees to an extension in writing.~~

~~**B.** Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.~~

~~**C.** Appeals and requests for hearing.~~

~~1. An applicant, eligible person, member, head of household, or designated representative may appeal and request a hearing regarding an adverse eligibility action by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:~~

~~a. The case name,~~

~~b. The adverse eligibility action being appealed, and~~

~~c. The reason for appeal.~~

~~2. A request for hearing shall be filed not later than 15 days after the date of the notice of adverse action by mailing or delivering it to either the county eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.~~

~~**D.** County responsibilities.~~

~~1. Counties shall maintain a register that documents the dates on which requests for hearings are submitted.~~

~~2. If requested, a county eligibility office shall assist an appellant or designated representative to complete of a Request for Hearing form.~~

~~3. A Pre-hearing Summary shall be completed by the county eligibility office and shall summarize the facts and factual basis for the adverse eligibility action.~~

~~4. The county eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-hearing Summary, a copy of the case file, and the Request for Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the county received the request for hearing. If the request for hearing is submitted directly to the Administration, the county shall send the materials to the Office of Grievance and Appeals not later than 10 days from the date of a request for the materials.~~

~~5. County review of eligibility determinations. If new information is acquired by the county that materially affects the adverse eligibility decision, the county shall complete a new application and render a decision according to the requirements specified in Article 3. The effective date of AHCCCS coverage shall be the date established in Article 3. A county decision in accordance with this subsection shall not be considered a disposition of a pending appeal.~~

E. AHCCCS coverage during the appeal process.
1. Eligible persons or members appealing a discontinuance. A discontinuance is a termination of AHCCCS benefits before the last month of an individual's certification period. The effective date of a discontinuance shall be the 16th day after the date of the Notice of Action. An eligible person or member appealing a discontinuance of AHCCCS benefits within the 15-day time-frame as specified in subsection (C) shall continue to be covered by AHCCCS until an adverse decision on appeal is rendered or until the end of the certification period set forth in R9-22-313, whichever comes 1st.
2. Individuals appealing a denial of AHCCCS coverage.
   a. A denial is an adverse eligibility decision that finds an applicant, eligible person, or member ineligible for AHCCCS benefits. A denial results from either an initial application or a redetermination that does not terminate benefits before the end of a current certification period.
   b. The effective date of a denial of an initial application is the date of the Notice of Action. An individual may appeal this denial within the 15-day time-frame specified in subsection (C). If the denial is overturned, the effective date of AHCCCS coverage shall be established by the Director in accordance with applicable law.
   c. The effective date of a denial of a redetermination shall be the last day of the final month in the current certification period. An individual who appeals this denial within the 15-day time-frame specified in subsection (C) shall continue to be covered by AHCCCS until administrative remedies are exhausted.
3. An individual whose benefits are continued shall be financially liable for all AHCCCS benefits received during a period of ineligibility if a discontinuance decision or redetermination denial is upheld by the Director.

R9-22-802. Grievance and Request for Hearing

A. General.
1. This Section provides the exclusive manner for filing a grievance against the Administration, its contractors, or both for any adverse action. The grievance process is illustrated in Exhibit A.
2. This Section shall not apply to an adverse action affecting a member's eligibility or to an adverse action that reduces a member's services as a result of a change in state or federal law.
3. If a hearing is requested, the hearing shall be conducted under A.R.S. § 41-1092.

B. Grievance to the Administration or a contractor.
1. Respondent.
   a. Administration. When grieving the Administration's adverse action, the Administration is the respondent.
   b. Contractor. When grieving a contractor's adverse action, the contractor is the respondent. The complainant shall file a grievance with the contractor responsible for the adverse action being grieved to allow the contractor to investigate and resolve the grievance.
2. Filing a grievance.
   a. Member grievance.
      i. A complainant shall file a grievance with the Administration or a contractor in writing or orally. An oral grievance shall be considered filed as of the date of the oral communication.
      ii. A complainant shall file a grievance with the Administration or a contractor no later than 60 days after the date of notice of the adverse action.
      iii. A grievance is not required to specify in detail the factual and legal basis for the grievance and the relief requested.
   b. Grievance other than a member grievance.
      i. A complainant shall file a grievance with the Administration or a contractor in writing.
      ii. A complainant shall file a grievance with the Administration or a contractor no later than 60 days after the date of notice of the adverse action except as provided in subsection (B)(2)(b)(iii).
      iii. A complainant shall file a grievance regarding a claim denial under the time-frames in A.R.S. § 36-2904.
      iv. A grievance shall specify in detail the factual and legal basis for the grievance and the relief requested. Failure to detail the factual or legal basis may result in the denial of a grievance.
3. Contractor's final decision of a grievance.
   a. Contractor's final decision. The contractor shall issue its final decision of the grievance to the complainant no later than 30 days after the filing of the grievance with the contractor, unless the complainant and contractor agree, in writing, to a longer period.
   b. Contents of contractor's final decision. The contractor's final decision shall include:
      i. The date of the decision;
      ii. The factual and legal basis for the decision;
      iii. The complainant's right to request a hearing under A.R.S. § 41-1092 et. seq.; and
      iv. The manner in which a request for hearing may be filed under A.R.S. § 41-1092 et. seq.

c. Request for hearing of contractor's final decision of grievance. A complainant may request a hearing under A.R.S. § 41-1092 et. seq. on the contractor's final decision of the grievance if:
   i. The complainant files a written request for hearing with the Administration no later than 30 days after the date of the contractor's final decision of the grievance; or
   ii. A final decision of the grievance under subsection (B)(3)(a) is not rendered by the contractor within 30 days after the filing of the grievance with the contractor, and the complainant files a written request for hearing under A.R.S. § 41-1092 et. seq. based on the contractor's failure or refusal to decide the grievance.

4. Administration's final decision of grievance.
   a. Administration's final decision. The Administration shall:
      i. Issue its final decision of the grievance to the complainant no later than 30 days after the filing of the grievance with the Administration, unless the complainant and Administration agree, in writing, to a longer period; or
      ii. Issue a notice of hearing under A.R.S. § 41-1092.03.
   b. Contents of Administration's final decision. The Administration's final decision shall include:
      i. The date of the decision;
      ii. The factual and legal basis for the decision;
      iii. The complainant's right to request a hearing under A.R.S. § 41-1092 et. seq.; and
      iv. The manner in which a request for hearing may be filed under A.R.S. § 41-1092 et. seq.
   c. Request for hearing of Administration's final decision of grievance. A complainant may request a hearing under A.R.S. § 41-1092 et. seq. on the Administration's final decision of the grievance if:
      i. The complainant files a written request for hearing with the Administration no later than 30 days after the date of the Administration's final decision of the grievance; or
      ii. A final decision of the grievance under subsection (B)(4)(a) is not rendered by the Administration within 30 days after the filing of the grievance with the Administration, and the complainant files a written request for hearing with the Administration based on the Administration's failure or refusal to decide the grievance.
5. Notice of hearing. The Administration shall issue a notice of hearing under A.R.S. § 41-1092.05 if the Administration or a contractor receives a timely request for hearing after the Administration or a contractor issues its final decision of grievance.

R9-22-803. Eligibility ~~Appeals for Applicants, Eligible Persons, and Members Receiving SSI-Related Medical Assistance Only AHCCCS Services~~ Hearing for an Applicant and a Member Under R9-22-1435, 9 A.A.C. 22, Article 15, and R9-22-1704

A. Adverse eligibility actions. ~~An applicant, eligible person, or member receiving SSI-related medical assistance only AHCCCS services may appeal and~~
1. A member or applicant may request a hearing ~~concerning~~ under A.R.S. § 41-1092 et. seq. on any of the following adverse eligibility actions:
   ~~1.~~a. Denial of ~~eligibility,~~ eligibility. A denial of eligibility is an adverse action that an applicant is ineligible for AHCCCS;
   ~~2.~~b. Discontinuance of ~~eligibility, or~~ eligibility. A discontinuance of eligibility is a termination of an AHCCCS member's eligibility;
   ~~3.~~c. Delay in the eligibility determination beyond the 45- or 90-day time-frame ~~prescribed in federal law~~ in R9-22-1502 from the date of ~~application~~ application, unless the applicant or representative agrees to ~~an extension in writing.~~ a written extension of time; or
   d. Adverse disability determination for an applicant under 9 A.A.C. 22, Article 15.
2. When requesting a hearing regarding an adverse eligibility action under this Section, the Administration is the respondent.

~~**B.** Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.~~

~~**C.**~~**B.** ~~Appeals and requests for hearing.~~ Request for hearing of an adverse eligibility action.
1. ~~An applicant, eligible person, member, or designated representative may appeal and~~ Requesting a hearing. A complainant may request a hearing ~~regarding~~ under A.R.S. § 41-1092 et. seq. for an adverse eligibility action ~~by completing and submitting the AHCCCS Request for Hearing form or by submitting a written request containing the following information:~~ no later than 30 days after the Administration's adverse eligibility action by:
   a. Submitting a request for hearing under A.R.S. § 41-1092 et. seq. to the Administration; or
   b. Submitting a written request to the Administration that contains the following information:
      ~~a.~~i. The case name,
      ~~b.~~ii. The adverse eligibility ~~action being appealed,~~ action, and
      ~~c.~~iii. The reason for ~~appeal.~~ the hearing.

~~2. For denials, the request for hearing shall be filed not later than 20 days from the date of the notice of adverse action. For discontinuances, the request for hearing shall be filed not later than 10 days after the effective date of action. The request for hearing shall be filed by mailing or delivering it to either the AHCCCS eligibility office or the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.~~

2. Notice of hearing. The Administration shall issue a notice of hearing under A.R.S. § 41-1092.05 if the Administration receives a timely request for hearing.

~~**D.** Eligibility office responsibilities.~~

~~1. The eligibility office shall maintain a register that documents the dates on which requests for hearings are submitted.~~

~~2. If requested, the eligibility office shall assist an appellant or designated representative to complete a Request for Hearing form.~~

~~3. A Pre-hearing Summary shall summarize the facts and factual basis for the adverse eligibility action.~~

~~4. The eligibility office shall send to the Administration, Office of Grievance and Appeals, the Pre-hearing Summary, a copy of the case file, and the Request for Hearing, which must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date the eligibility office received the request for hearing. If the request for hearing is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the office of Grievance and Appeals not later than 10 days from the date of a request for the materials.~~

~~E.~~C. AHCCCS coverage and benefits during the ~~appeal~~ hearing process under A.R.S. § 41-1092 et. seq.

1. ~~Eligible persons or members appealing a discontinuance. A discontinuance is a termination of AHCCCS benefits.~~ For ~~actions requiring 10 days'~~ a discontinuance action that requires 10-day advance notice, ~~an eligible person or~~ a member ~~requesting a hearing~~ whose request for hearing is filed before the effective date of the ~~adverse action~~ discontinuance shall continue to receive AHCCCS ~~benefits~~ coverage until ~~an adverse decision on the appeal is rendered.~~ a final administrative decision is rendered under A.R.S. § 41-1092.08. A member may waive coverage while the administrative decision is pending.

~~2. Applicants appealing a denial of AHCCCS coverage.~~

   ~~a. A denial is an adverse eligibility decision that finds an applicant ineligible for AHCCCS benefits.~~

   ~~b. An applicant may appeal a denial within the time-frames specified in subsection (C)(2). If the denial is overturned, the effective date of AHCCCS coverage shall be established by the Director in accordance with applicable law.~~

~~3.~~2. ~~An eligible person or~~ A member whose benefits are continued ~~shall~~ may be financially liable for all AHCCCS benefits received during a period of ~~ineligibility if a discontinuance decision is upheld by the Director.~~ ineligibility if a discontinuance decision is upheld under A.R.S. § 41-1092.08.

3. A member who requests a hearing regarding the termination of family planning services under R9-22-1435 or the guaranteed enrollment period under R9-22-1704 shall not continue to be AHCCCS-eligible after the end of the designated time period under A.R.S. § 36-2907.04 and 42 U.S.C. 1396a(e)(2). If the termination of family planning services is overturned, the applicable effective date of AHCCCS coverage shall be set forth in the decision under A.R.S. § 41-1092.08.

D. Effective date of an overturned denial of AHCCCS eligibility. If a denial of eligibility is overturned during the hearing process, the applicable effective date of AHCCCS eligibility shall be set forth in the decision under A.R.S. § 41-1092.08.

~~R9-22-804.~~ ~~Grievances~~ Repealed

~~**A.** This Section provides the exclusive manner through which any individual or entity may grieve against the Administration, its contractors, or both in connection with any adverse action, decision, or policy. This Section shall not apply to actions or decisions affecting an eligible person's or member's eligibility or to actions or decisions that reduce a categorically eligible person's or member's benefits as a result of changes in state or federal law.~~

~~**B.** Direct grievances to the Administration.~~

~~1. A grievance may be filed directly with the agency only by individuals not enrolled with a contractor; by contractors; by counties; and by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the Administration. If the aggrieved adverse action, decision, or policy actually was made by a contractor, the appellant shall first file the grievance with the contractor responsible for the decision, policy, or action being grieved, so the contractor may investigate and resolve the grievance in accordance with this Article and any applicable contracts.~~

~~2. Except as provided in subsection (B)(3) a written grievance shall be filed with and received by the Administration not later than 35 days after the date of the adverse action, decision, or policy implementation being grieved.~~

~~3. A written grievance regarding a claim denial shall be filed not more than 12 months after the date of the service for which payment is claimed. A grievance challenging a reinsurance claim denial by the Administration shall be filed not more than 12 months after the close of the contract year in which the claim was incurred. If the claim is denied less than 35 days before expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.~~

~~4. A grievance shall state with particularity the factual and legal basis for the grievance and the relief requested. Failure to comply with this specificity requirement shall result in the denial of the grievance.~~
~~5. The Administration, in its sole discretion, may investigate a grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.~~
~~6. If a hearing is requested, it shall be conducted as provided in R9-22-801.~~

~~C. Grievances to contractors.~~
~~1. Except as provided in subsection (C)(2) a grievance shall be filed with and received by the appropriate contractor not later than 35 days after the date of the adverse action or decision. Members may file grievances orally.~~
~~2. A written grievance regarding a claim denial shall be filed not more than 12 months after the date of the service for which payment is claimed.~~
~~3. A grievance shall state with particularity the factual and legal basis for the grievance and the relief requested. Failure to comply with this specificity requirement shall result in the denial of the grievance.~~
~~4. A final decision shall be rendered by the contractor on all grievances within 30 days of filing unless the parties agree on a longer period. The decision by the contractor shall be personally delivered or mailed by certified mail to the parties, and shall state the basis for the decision as well as the grievant's right to appeal the decision to the Administration. The contractor's final decision shall specify the manner in which an appeal to the Administration may be filed.~~
~~5. The contractor shall record and retain information to identify the grievant, date of receipt, and nature of the grievance.~~
~~6. At the time of enrollment, a contractor shall give to a member written information regarding grievance procedures available through the contractor and the Administration.~~

~~D. Appeal of contractor decisions to the Administration.~~
~~1. After first grieving to the appropriate contractor, a grievant may appeal to and request a hearing from the Administration, Office of Grievance and Appeals if:~~
~~a. The grievant files a written notice of appeal not more than 15 days from the date of final decision of the contractor, which is the earlier of the date of personal delivery or the postmark date of certified mail; or~~
~~b. A decision is not timely rendered by the contractor until 30 days, and the grievant files a written notice of appeal based upon the contractor's failure or refusal to decide the grievance in a timely manner.~~
~~2. The Administration, in its sole discretion, may investigate a grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days from the postmark date of the informal decision of the Administration.~~
~~3. If a hearing is requested, it shall be conducted as provided in R9-22-801.~~

R9-22-804. Eligibility Hearing for an Applicant and a Member Under 9 A.A.C. 22, Article 16

A. County adverse eligibility actions.
1. A member or applicant under 9 A.A.C. 22, Article 16 may request a hearing under A.R.S. § 41-1092 et. seq. on any of the following adverse eligibility actions:
   a. Denial of eligibility. The county's denial of eligibility of:
      i. An initial application, or
      ii. A redetermination of eligibility if the redetermination of eligibility does not terminate coverage before the end of a current certification period;
   b. The county's discontinuance of a member's coverage before the end of the member's current certification period;
   c. The county's delay in an eligibility determination beyond 30 days after the date of application unless the head-of-household agrees to a written extension of time; or
   d. The county's approval of a certification period ending less than 6 full calendar months following the date of determination of eligibility under R9-22-1615.
2. If the county eligibility staff acquires new information that reverses the denial under subsection (A)(1)(a) or discontinuance under subsection (A)(1)(b), the county eligibility staff shall cancel the adverse eligibility action and render a new eligibility action under the requirements specified in 9 A.A.C. 22, Article 16. The county eligibility staff's final eligibility determination is the effective date of AHCCCS eligibility under this subsection.
3. When requesting a hearing regarding an adverse eligibility action under this Section, the county is the respondent.

B. Request for hearing of a county's adverse eligibility action.
1. Requesting a hearing. A complainant may request a hearing under A.R.S. § 41-1092 et. seq. for an adverse eligibility action no later than 30 days after the Administration's adverse eligibility action by:
   a. Submitting a request for hearing under A.R.S. § 41-1092 et. seq. to the Administration; or
   b. Submitting a written request to the Administration that contains the following information:
      i. The case name,
      ii. The adverse eligibility action, and
      iii. The reason for the hearing.
   2. Notice of hearing. The Administration shall issue a notice of hearing under A.R.S. § 41-1092.05 if the Administration receives a timely request for hearing.

3. The county eligibility staff's action, under subsection (A)(2), to cancel the adverse eligibility action and render a new determination is not a disposition of a pending request for hearing under A.R.S. § 41-1092 et. seq.

C. County responsibilities.

1. The county eligibility staff shall maintain a register documenting the date a request for hearing under A.R.S. § 41-1092 et. seq. is received by county eligibility staff.
2. If requested, county eligibility staff shall assist a complainant or designated representative in completing a request for hearing under A.R.S. § 41-1092 et. seq.
3. The county eligibility staff shall complete a pre-hearing summary that summarizes the factual basis for an adverse eligibility action described in subsection (A)(1) and which is the basis of a request for hearing under A.R.S. § 41-1092 et. seq.
4. County eligibility staff shall send to the Administration a pre-hearing summary, a copy of the case file, and the request for hearing under A.R.S. § 41-1092 et. seq.:
   a. To ensure that the Administration receives the materials no later than 10 days after the date the county received the complainant's request for hearing under A.R.S. § 41-1092 et. seq.; or
   b. Ten days after the date the Administration requests the materials, for a request for hearing under A.R.S. § 41-1092 et. seq. submitted directly to the Administration.

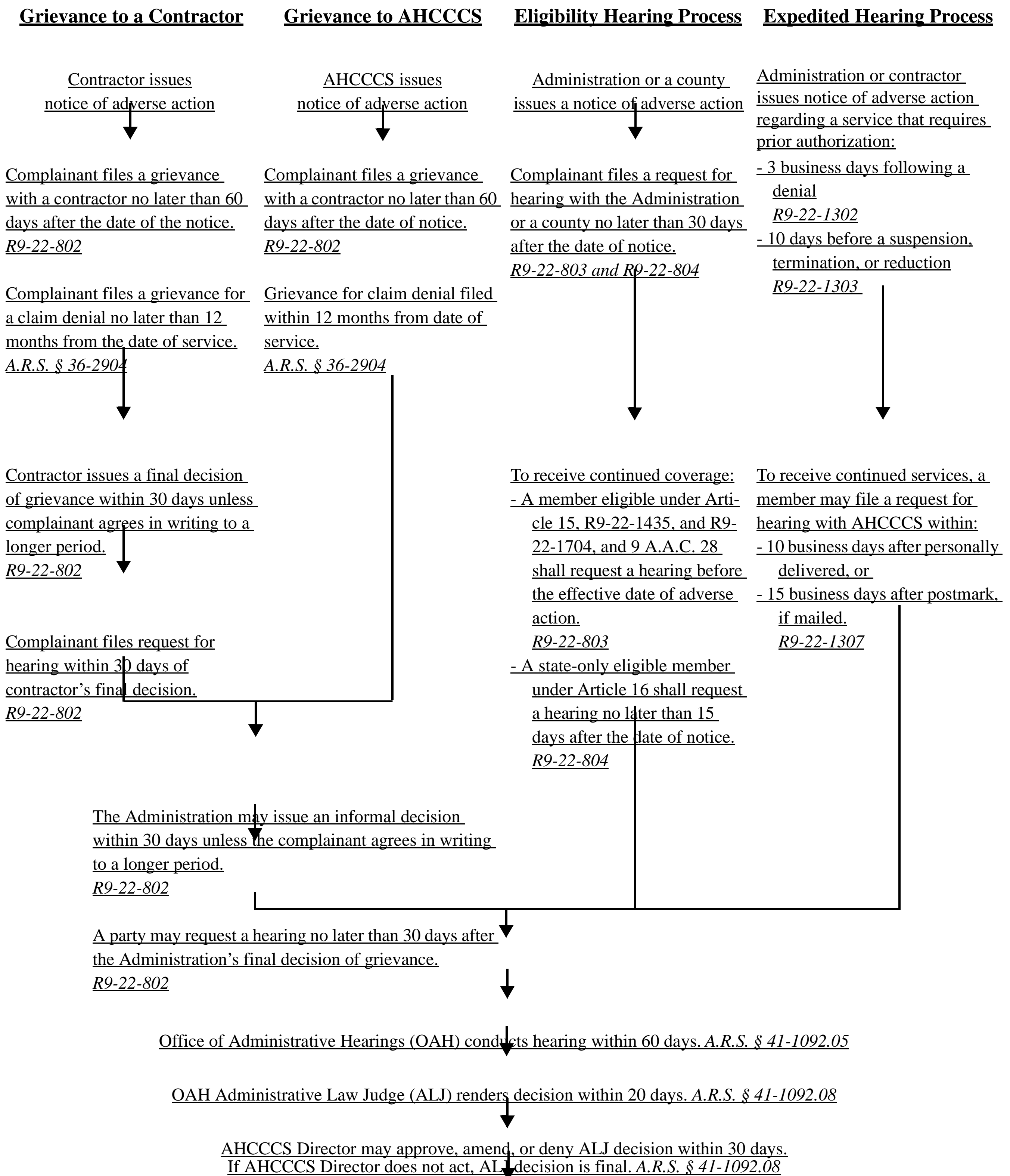
D. AHCCCS coverage and benefits during the hearing process under A.R.S. § 41-1092 et. seq.

1. A member who requests a hearing regarding a discontinuance of MI/MN or ELIC coverage no later than 15 days after the date of notice of the adverse action shall continue to receive AHCCCS coverage until the earlier of:
   a. A final administrative decision is rendered under A.R.S. § 41-1092.08, or
   b. The end of the certification period described in R9-22-1615.
2. A member whose coverage is continued under subsection (D)(1) may be financially liable for all AHCCCS benefits received during a period of ineligibility if a discontinuance decision is upheld under A.R.S. § 41-1092.08

E. Effective date of an overturned denial of AHCCCS eligibility.

1. Initial application. The effective date of a denial of an initial application is the date of the notice of action of eligibility. If the denial of an initial application is overturned during the hearing process, the applicable effective date of AHCCCS eligibility shall be set forth in the decision under A.R.S. § 41-1092 et. seq.
2. Redetermination. The effective date of a denial of an eligibility redetermination is the last day of the final month of the person's current certification period. A member or applicant who requests a hearing under A.R.S. § 41-1092 et. seq. regarding a denial of an eligibility redetermination shall not continue to be AHCCCS-eligible after the end of the current certification period. If the denial of an eligibility redetermination is overturned during the hearing process, the applicable effective date of AHCCCS eligibility shall be set forth in the decision.

Exhibit A. Grievance and Request for Hearing Process



ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1208. Grievance and ~~Appeal~~ Request for Hearing Process

A. Processing ~~of~~ a grievance. ~~All grievances regarding any~~ A grievance for an adverse ~~action, decision, or policy regarding~~ action for a behavioral health ~~services~~ service shall be ~~reviewed~~ ~~according to~~ processed as specified in 9 A.A.C. 22, Articles 8 and 13 and under A.R.S. §§ 36-2903.01, 36-3413, ~~41-1092.02 and 9 A.A.C. 22, Article 8 and 9 A.A.C. 22, Article 13.~~ and 41-1092 et. seq. The grievance and request for hearing process is illustrated in 9 A.A.C. 22, Article 8, Exhibit A.

B. Member ~~appeal.~~ request for hearing. A member's ~~appeal of~~ request for hearing for a grievance under this Article shall be conducted ~~as a contested case~~ as specified in 9 A.A.C. 22, Article 8.

~~**C.** Other appeals. An appeal of the ADHS director's decision after an Office of Administrative Hearing decision other than de novo hearing requests by a member shall be limited to an appellate review by the Administration to determine whether substantial evidence in the record supports the decision.~~

ARTICLE 13. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

R9-22-1301. General Intent and Definitions

A. General.

1. This Article defines the notice and ~~appeal~~ expedited request for hearing under A.R.S. § 41-1092 et. seq. process when the Administration or a contractor denies, reduces, suspends, or terminates a service ~~and provides a party with the opportunity for an expedited hearing.~~ that requires prior authorization. This Article provides an expedited hearing request process and opportunity for continued services as an alternative to the provisions of 9 A.A.C. 22, Article 8. The expedited hearing request process is illustrated in 9 A.A.C. 22, Article 8, Exhibit A.
2. The 30-day time-frame for filing a request for hearing under A.R.S. § 41-1092 et. seq. begins with the date that the notice of adverse action is dated.

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

~~1.~~ "Action" means a denial, termination, suspension, or reduction of a ~~covered service as defined in R9-22-102.~~ service.

~~2.~~ "Contractor" means a health plan, ALTCS program contractor, the Arizona Department of Health ~~Services,~~ Services Division of Behavioral Health Services, or a Tribal or Regional Behavioral Health Authority.

~~3. "Date of action" means the effective date for a termination, suspension, or reduction.~~

~~4. "Denial" means the decision not to authorize a requested service.~~

~~5.~~ "Notice" means a written statement that meets the requirements specified in R9-22-1304.

~~6.~~ "Party" means a member, contractor, or the Administration.

~~7. "Request for a hearing" means a clear expression by a member or a member's authorized representative that the member wants the opportunity to present the member's case to a reviewing authority.~~

R9-22-1302. Denial of a Request for a Service

The Administration or a contractor shall provide a member with written notice no later than 3 business days ~~from~~ after the date ~~when~~ the Administration or a contractor denies authorization for a requested service ~~is denied by the party giving notice.~~ that the member does not currently receive.

R9-22-1303. Reduction, Suspension, or Termination of a Service

Except as permitted under R9-22-1305 and R9-22-1306, if the Administration or contractor reduces, suspends, or terminates a service currently provided by the Administration or contractor, the Administration or contractor shall provide the member written ~~Notice of Intended Action~~ notice at least 10 days ~~prior to~~ before the effective date of the intended action.

R9-22-1304. Content of Notice

A ~~Notice of Intended Action,~~ notice required under R9-22-1302 or R9-22-1303 ~~of this Article,~~ shall contain the following:

1. A statement of the action the Administration or a contractor has taken or intends to take;
2. The ~~succinct and~~ specific reason for the ~~intended action;~~ action, including the facts, specific to the member, that support the action;
3. The specific ~~law or rule~~ law, rule, or other written policy, standards, or criteria that ~~supports~~ support the action, or the specific change in federal or state law that authorizes the action;

~~4. A change in federal or state law that requires an action;~~

~~5.~~4. An explanation of:
   a. A member's right to request an evidentiary hearing under A.R.S. § 41-1092 et. seq.; and
   b. The circumstances under which the Administration or a contractor shall grant a hearing under A.R.S. § 41-1092 et. seq. for an action based on a change in the law; and

~~6.~~5. An explanation of the circumstance under which the Administration or a contractor shall continue a covered service if a member ~~appeals an action for a:~~ requests a hearing regarding a service that is:
   a. ~~Reduction,~~ Reduced,
   b. ~~Suspension,~~ Suspended, or
   c. ~~Termination of a service.~~ Terminated.

R9-22-1305. Exceptions from an Advance Notice

The Administration or a contractor may mail a ~~Notice of Intended Action~~ notice for a reduction, suspension, or termination of a service ~~not~~ no later than the date of ~~action if~~ the ~~Administration~~ Administration's or a ~~contractor:~~ contractor's action if the Administration or a contractor:

1. Has factual information confirming the death of a member;
2. Receives a written statement signed by the member that:
   a. States services are no longer wanted; or
   b. Provides information ~~which~~ that requires a reduction or termination of a service and indicates that the member understands that a reduction or termination of a service shall be the result of ~~providing~~ that information;
3. Learns that a member has been admitted to an institution ~~which~~ that makes the member ineligible for services;
4. Does not know the member's whereabouts and mail directed to the member is returned by the post office and no forwarding address is provided;
5. Has established the fact that the member has been approved for Medicaid services outside the state of Arizona;
6. Knows that a member's primary care provider has prescribed a change in the level of medical care; or
7. Knows the ~~Notice of Intended Action~~ notice involves an adverse determination for preadmission screening requirements specified in A.R.S. § 36-2936 for an ALTCS member.

R9-22-1307. Expedited Hearing Process

~~A.~~ ~~Alternative hearing process. This Section provides an alternative expedited hearing process for denials defined in R9-22-1301(B)(4) and an alternative expedited hearing process and continued services for actions defined in R9-22-1301(B)(1). Except as stated in this Section, the provisions of 9 A.A.C. 22, Article 8 do not apply. If the Administration determines that a request for hearing filed according to this Section is not timely or not a proper appeal of a denial or action as defined in R9-22-1301(B), the request for hearing shall instead be considered a grievance according to 9 A.A.C. 22, Article 8 and, if appropriate, forwarded to the contractor within 10 business days from the date the Administration receives the request for processing according to 9 A.A.C. 22, Article 8. In this event, services shall not be continued as provided in this Section. If a member does not seek continued services or an expedited hearing, the member may file a grievance according to 9 A.A.C. 22, Article 8.~~

A. Request for expedited hearing.
1. A member is entitled to an expedited hearing if:
   a. The Administration or contractor denies, reduces, suspends, or terminates a service that requires authorization by either the Administration or the contractor; and
   b. The member files the request for expedited hearing with the Administration or the contractor:
      i. No later than 10 business days after personal delivery of the notice of action; or
      ii. No later than 15 business days after the postmark date, if mailed, of the notice of action.
2. A member who files a request for expedited hearing may continue to receive the service as specified in subsection (D) pending a hearing decision under A.R.S. § 41-1092.08 if:
   a. The Administration or contractor reduces, suspends, or terminates a service that requires authorization by either the Administration or contractor; and
   b. The member files a request for continued services at the same time that the member files the request for expedited hearing specified in subsection (A)(1)(b).

~~B.~~ ~~Time-frames. If the Administration or a contractor denies a service that requires authorization or reduces, suspends, or terminates existing service; and the member appeals the action and requests continued services during the hearing process or requests an expedited hearing of a denial for authorization, a member must file a request for hearing:~~
~~1.~~ ~~No later than 10 business days from the date of personal delivery of the Notice of Intended Action to the member; or~~
~~2.~~ ~~No later than 15 business days from the postmark date, if mailed, of the Notice of Intended Action.~~

~~C.~~**B.** Expedited hearing.
1. A hearing under ~~this Section~~ subsection (A) shall be held no sooner than 20 ~~days~~ days, and ~~not~~ no later than 40 days ~~from~~ after the ~~Administration's receipt of~~ Administration or contractor receives the request for ~~hearing.~~ expedited hearing; or
2. ~~Alternatively, the~~ A hearing may be held sooner than 20 days ~~upon the written agreement of all of the parties or upon~~ if:
   a. A request for hearing under A.R.S. § 41-1092 et. seq. is filed with the Administration or contractor; and
   b. All the parties agree, in writing; or

c. Upon ~~written~~ motion of 1 of the parties ~~establishing, in the discretion of the Administration, extraordinary circumstances or the possibility of irreparable harm if the hearing is not held sooner.~~ under A.R.S. § 41-1092.05.

~~D.~~C. Notice of hearing date. The Administration shall provide notice of the hearing date under A.R.S. § 41-1092 et. seq. to the member or the authorized representative and to all other parties to the ~~appeal.~~ hearing.

~~E.~~D. ~~Responsibilities of the Administration or a contractor. The~~ Continued services. If a request for expedited hearing under A.R.S. § 41-1092 et. seq. and a request for continued services is timely filed under this Section, the Administration or the contractor shall ~~provide the current level of an existing service~~ not terminate, reduce, or suspend the service during the expedited hearing ~~process, if a request for expedited hearing and request to continue services are properly filed according to this Section.~~ process.

~~F.~~E. Previously authorized service:

1. ~~If a member's primary care provider orders a service that was previously authorized for the member, the Administration or a contractor may issue a written denial according to R9-22-1302, if the Administration or a contractor considers the request new and independent of any previous authorization. If the member's primary care provider asserts that the requested service or treatment is a necessary continuation of the previous authorization, and the member challenges the denial on this basis, then the service shall be continued pending appeal, unless:~~ In addition to services that are continued under subsection (D), the Administration or contractor shall continue services pending a hearing decision under A.R.S. § 41-1092.08 if:

   a. The Administration or contractor denies an authorization for a previously authorized service for the member because the Administration or contractor considers the service new and independent of any previous authorization; and

   b. The member's primary care physician asserts that the requested service is a necessary continuation of the previous authorization; and

   c. The member challenges the denial on this basis and timely requests continued services.

2. Services shall not be continued if:

   a. The parties reach ~~some other~~ a written agreement, or

   b. The Administration or contractor believes the primary care provider's request endangers the member.

~~2. Any dispute regarding reimbursement of a service under this Section is reserved until the provider submits a claim.~~

~~G.~~F. ~~Responsibility~~ Financial liability of a member. A member whose service is continued ~~during the expedited hearing process~~ pending a hearing decision under A.R.S. § 41-1092.08 is financially liable for the service received if ~~the Director upholds the~~ a decision to reduce, suspend, or terminate ~~the service.~~ is upheld under A.R.S. § 41-1092.08.

~~H.~~G. General provisions. ~~The~~ If an expedited hearing ~~process~~ is requested, the hearing shall be conducted ~~according to R9-22-801 subsections (A) through (E) and (G) through (M).~~ under A.R.S. § 41-1092 et. seq.

H. Alternative hearing process. A request for expedited hearing shall be considered a grievance under 9 A.A.C. 22, Article 8, and the Administration shall forward the request for hearing to the contractor within 10 business days after the day the Administration receives the request if:

1. The Administration determines that the request for expedited hearing filed under this Section is not timely, as determined by the Office of Legal Assistance's date stamp on the request; or

2. The request for hearing does not involve the denial, reduction, suspension, or termination of a service.

R9-22-1308. Maintenance of Records

The ~~party providing Notice of Intended Action~~ Administration or contractor shall maintain records of the written notification and the date of the notice under R9-22-1302 and R9-22-1303 given to ~~the~~ each member.

R9-22-1309. Member Handbook

A contractor shall furnish each member with a handbook, as specified in contract, that explains a member's right to file a grievance or ~~appeal~~ request a hearing under A.R.S. § 41-1092 et. seq. concerning ~~a denial or~~ an action that affects a member's receipt of medical services.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-27-101	Amend
R9-27-201	Amend
R9-27-202	Amend
R9-27-203	Amend
R9-27-204	Amend
R9-27-205	Amend
R9-27-206	Amend
R9-27-207	Amend
R9-27-208	Amend
R9-27-209	Amend
R9-27-210	Amend
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-304	Repeal
R9-27-305	Amend
R9-27-306	Amend
R9-27-307	Amend
R9-27-308	Amend
R9-27-309	Amend
R9-27-310	Amend
R9-27-401	Amend
R9-27-402	Amend
R9-27-403	Amend
R9-27-404	Amend
R9-27-406	Amend
R9-27-407	Amend
R9-27-501	Amend
R9-27-502	Amend
R9-27-503	Amend
R9-27-504	Amend
R9-27-505	Amend
R9-27-506	Amend
R9-27-509	Amend
R9-27-510	Amend
R9-27-511	Amend
R9-27-512	Amend
R9-27-513	Amend
R9-27-514	Amend
R9-27-515	Amend
R9-27-516	Amend
Article 6	Amend
R9-27-601	Amend
R9-27-701	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Amend
R9-27-801	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. § 36-2912(A) and (G)(6)

Implementing statutes: A.R.S. § 36-2912(E) and (G)(6), and 41-1092.02 et. seq

3. The effective date of the rules:

August 7, 2000

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 659, February 11, 2000

Notice of Rulemaking Docket Opening: 5 A.A.R. 3230, September 17, 1999

Notice of Proposed Rulemaking: 6 A.A.R. 992, March 17, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 1368, April 14, 2000

Notice of Public Information: 6 A.A.R. 1445, April 14, 2000

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

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: 801 East Jefferson, Mail Drop 4200
Phoenix, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

All 8 Articles in 9 A.A.C. 27 have been opened for the following reasons:

a. To make the language conform with Arizona Revised Statute, United States Code, and current agency practice by:

i. Changing definition of "full-time employee" to be consistent with A.R.S. § 36-2912.04,

ii. Changing definition of "pre-existing condition" to be consistent with A.R.S. § 36-2912.04 and 42 U.S.C. 300gg,

iii. Conforming rules to be consistent with 42 U.S.C. 300gg(d), which strikes the exclusion of inpatient costs for the delivery of a child in the 10 months after the effective date of coverage,

iv. Added definition of "pre-existing condition exclusion" to be consistent with A.R.S. § 20-2308 and 42 U.S.C. 300gg,

v. Changing time-frame of portability of prior coverage to be consistent with A.R.S. § 20-2308 and 42 U.S.C. 300gg(c)(2),

vi. Increasing maximum size of employer group to be consistent with A.R.S. § 36-2912(B)(3),

vii. Increasing percentage of employees in an employer group who are required to participate in the Healthcare Group (HCG) to conform to A.R.S. § 36-2912,

viii. Clarifying the time-frames required to terminate a contract between a HCG Plan and an employer group as specified in A.R.S. § 36-2912(O), and

ix. Changing Article 6 – "Grievance and Request for Hearings" – to comply with A.R.S. § 41-1092 et. seq. and A.R.S. § 36-2903.01(B)(4). Changes implemented on July 1, 1999 moved the hearing process from the Healthcare Group Administration (HCGA) to the Office of Administrative Hearings (OAH); and

b. To make the language more clear, concise, and understandable.

7. A reference to any study that the agency relied on in its evaluation of or justification for the 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

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

Not applicable

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

The following entities will benefit from changes made largely in response to changes in federal and state law:

a. Healthcare Group Administration (HCGA);
b. Office of Administrative Hearings (OAH); and
c. Health plans.

Employer groups and their employees may be minimally to significantly impacted by changes made to conform to federal and state law. Included within employer groups and employees are 3 political subdivisions, which HCG serves and which may participate in the HCG. However, not all of employer groups will be impacted in the same way. While some employer groups will continue to be eligible for the HCG, others may not. Losing access to the HCG could be considered a significant impact. However to try and ensure the financial viability of the program, the legislature passed laws to strengthen the program so that the program may continue. If the program does not continue because it is not financially viable, all current employers would not have access to this affordable insurance.

Health care providers may be indirectly impacted by changes made to conform to changes in federal and state law. Such changes may shift who is and remains an HCG member and consequently whom an HCG provider sees. Other proposed changes may minimally impact providers, though ultimately be of benefit by having the program continue.

Finally, the following groups were considered but will not be directly affected by proposed changes:

a. Taxpayers; and
b. The larger business community, except for AHCCCS health plans, providers, and current and potential employer groups of less than 50 employees.

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

#	Subsection	Recommendation
1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, structural, and punctuation changes throughout the rules.
2.	R9-27-101	The Administration added “entity” to the definition of “complainant” to clarify that contractors may be complainants.
3.	R9-27-101	The Administration added a definition of “party” to make the rules more clear, concise, and understandable.
4.	R9-27-405	The Administration removed this Section from the final rulemaking process that originally appeared in the proposed rulemaking. The Administration will review this Section at a future date.
5.	R9-27-507	The Administration removed this Section from the final rulemaking process that originally appeared in the proposed rulemaking. The Administration will review this Section at a future date.
6.	R9-22-601	The Administration amended the rules to require the Administration to issue a decision no later than 30 days after receipt of the grievance or request for hearing unless the complainant agree to an extension.
7.	R9-27-601 (G)(3) R9-27-601 (H)(2)	The Administration corrected the statutory references to A.R.S. § 36-2903.01 by replacing them with references to A.R.S. § 36-2904 because the anticipated statutory change did not pass.
8.	R9-27-601 (D)	The Administration amended the language to clarify that nonprivileged documents are those that are not protected from disclosure by law.

9.	R9-27-601	The Administration amended the language to clarify that the Director may grant a motion for rehearing or review if good cause for not appearing at a hearing is established. The Administration deleted the language regarding the actions that the HCGA may take on a motion for rehearing or review because these are in A.R.S. § 41-1092.09.
10.	R9-27-601	The Administration clarified that a request for hearing regarding a policy may be denied because it is not subject to OAH's jurisdiction under A.R.S. § 41-1092.
11.	R9-27-601	The Administration reorganized the Section to make the language more clear, concise, and easy to understand.
12.	R9-27-601	The Administration added language to clarify that a complainant may request a hearing if the Administration fails or refuses to decide the grievance within 30 days.
13.	R9-27-601	The Administration changed the 35-day time-frame for filing a request for hearing to be consistent with the 30-day requirement in OAH statute.
14.	R9-27-101	The Administration amended the language to clarify that the Administration will issue a notice of hearing if the Administration receives a timely request for hearing.

11. A summary of the principal comments and the agency response to them:

The Administration conducted a videoconference public hearing in Phoenix, Flagstaff, and Tucson, Arizona and an additional public hearing in Casa Grande, Arizona on May 16 and 17, 2000. No one attended either public hearing.

Before the close of record, 5:00 p.m., Wednesday, May 17, 2000, the Administration received written comments from Coconino County. The Administration conducted a conference call with Coconino County to discuss the Administration's response to each comment. The Administration amended the language to clarify that "nonprivileged documents" refers to those which are "not protected from disclosure by law" in response to a comment from Coconino County. Coconino County requested to extend the 24 and 48-hour time-frames for notifying a HCG Plan in R9-27-209 to 72 hours. The Administration did not change the rules because they are consistent with those used by commercial carriers. To the greatest extent possible, Healthcare Group Administration administers the program to be consistent with commercial carriers. Coconino County also requested that the Administration change the definition of a full-time employee from 32 hours to 20 hours. A.R.S. § 36-2912 requires a full-time employee to work for a minimum of 32 hours per week.

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

Not applicable

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

42 U.S.C. 1396u-2, August 5, 1997, incorporated in R9-27-209(A)(1)

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Definitions

ARTICLE 2. SCOPE OF SERVICES

Sections
R9-27-201. Scope of Services
R9-27-202. Covered Services
R9-27-203. Excluded Services
R9-27-204. Out-of-Service Area Coverage
R9-27-205. Outpatient Health Services
R9-27-206. Laboratory, Radiology, and Medical Imaging Services

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

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Sections
R9-27-301. Eligibility Criteria for Employer Groups
R9-27-302. Eligibility Criteria for Employee Members
R9-27-303. Eligibility Criteria for Dependents
~~R9-27-304.~~ ~~Employer Group Member Eligibility Verification~~ Repealed
R9-27-305. Health History Form
R9-27-306. Effective Date of Coverage
R9-27-307. Open Enrollment of Employee Members
R9-27-308. Enrollment of Newborns
R9-27-309. Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage
R9-27-310. Denial and Termination of Enrollment

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

Sections
R9-27-401. General
R9-27-402. Contracts
R9-27-403. Subcontracts
R9-27-404. Contract Amendments
R9-27-406. Continuation Coverage
R9-27-407. Conversion Coverage

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Sections
R9-27-501. Availability and Accessibility of Services
R9-27-502. Reinsurance
R9-27-503. Marketing, Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions
R9-27-504. Approval of Advertisements and Marketing Material
R9-27-505. Member Records and Systems
R9-27-506. Fraud or Abuse
R9-27-509. Information to Enrolled Members
R9-27-510. Discrimination Prohibition
R9-27-511. Equal Opportunity
R9-27-512. Periodic Reports and Information
R9-27-513. Medical Audits
R9-27-514. HCG Plan's Internal Quality Management and Utilization Review System
R9-27-515. Continuity of Care
R9-27-516. Financial Resources

ARTICLE 6. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

Section
R9-27-601. ~~Grievances and Appeals~~ Grievance and Request for Hearing

ARTICLE 7. STANDARD FOR PAYMENTS

Sections
R9-27-701. ~~Scope of the HCGA's~~ HCGA Liability; Payments to HCG Plans
R9-27-702. Prohibition Against Charges to Members
R9-27-703. Payments by HCG Plans
R9-27-704. HCG Plan's Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
R9-27-705. Copayments

ARTICLE 8. COORDINATION OF BENEFITS

Section
R9-27-801. Priority of Benefit Payment

ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, unless the context explicitly requires another meaning:

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

~~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 member.

“Administrative law judge” means the person defined in A.R.S. § 41-1092.

“Adverse action” means any action under this Chapter, including adverse eligibility actions, for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et. seq. under 9 A.A.C. 27, Article 6.

“Administrative review” means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et. seq.

~~2.~~ “Ambulance” means any vehicle defined in A.R.S. § 36-2201~~(2)~~.

“Certification” as specified in 29 U.S.C. 1181.

~~3.~~ “Clean claim” means ~~1~~ a claim that can be processed without obtaining additional information from the provider of the service or from a ~~3rd party~~ 3rd-party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

~~4.~~ “Coinsurance” means a ~~predetermined~~ pre-determined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

“Complainant” means an applicant, member, person, or entity filing a grievance or request for hearing.

~~5.~~ “Copayment” means a monetary amount specified by the ~~Healthcare Group Administration~~ HCGA ~~which~~ that a member or dependent pays directly to a provider at the time a covered ~~services~~ service ~~are~~ is rendered.

~~6.~~ “Covered services” means the health and medical services described in ~~R9-27-202~~ 9 A.A.C. 27, Article 2.

“Creditable coverage” as defined in A.R.S. § 36-2912.04

“Date of notice” means the date on a notice of action.

~~7.~~ “Day” means a calendar day unless otherwise specified in the text.

~~8.~~ “Deductible” means a fixed annual dollar amount a member agrees to pay for certain covered services before the ~~Healthcare Group~~ HCG Plan agrees to pay.

~~9.~~ “Dependent” means the eligible spouse and children of an employee member under ~~R9-27-303~~ 9 A.A.C. 27, Article 3.

~~10.~~ “Eligible employee” means an employee who is eligible for ~~Healthcare Group~~ HCG coverage under ~~R9-27-302~~ 9 A.A.C. 27, Article 3.

~~11.~~ “Emergency ambulance service” means:

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

~~12.~~ “Emergency medical services” means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing ~~the~~ a patient’s health in serious jeopardy~~;~~,
b. Serious impairment to bodily functions~~;~~, or
c. Serious dysfunction of any bodily organ.

~~13.~~ “Employer group” means the aggregate enrollment of an employed group or business that is contracting with ~~a Healthcare Group~~ an HCG Plan for covered services.

~~14.~~ “Employee member” means an enrolled employee of an employer group.

~~15.~~ “Enrollment” means the process by which an employer group or a member applies for coverage and contracts with ~~a Healthcare Group~~ an HCG Plan.

~~16.~~ “Full-time employee” means an employee who works at least ~~20~~ 32 hours per week and expects to continue employment for at least 5 months following enrollment.

~~17.~~ “Grievance” means a complaint ~~arising from an adverse action, decision, or policy by a Healthcare Group Plan, subcontractor, noncontracting provider, or the Healthcare Group Administration HCGA, presented by an individual or entity specified in R9-27-601.~~ that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et. seq. A party may request a hearing under A.R.S. § 41-1092 et. seq. after an administrative review.

~~18.~~ ~~“Group Service Agreement (GSA)” means~~ “GSA” means Group Service Agreement, a contract between an employer group and ~~a Healthcare Group~~ an HCG Plan.

“Healthcare Group Administration (HCGA)” means the section within AHCCCS that directs and regulates the continuous development and operation of the HCG Program.

~~19.~~ ~~“Healthcare Group of Arizona (HCG)”~~ “HCG” means ~~the~~ Healthcare Group of Arizona the registered name of the Healthcare Group Program, ~~which is~~ a prepaid medical coverage product marketed by the Healthcare Group Plans to small uninsured businesses and political subdivisions within the state.

~~20.~~ ~~“Healthcare Group Administration (HCGA)” means the section within AHCCCS that directs and regulates the continuous development and operation of the HCG Program.~~

~~21.~~ ~~“Healthcare Group Plan (HCG Plan or Plan)”~~ “HCG Plan” means a Healthcare Group prepaid health plan that is currently under contract with the HCGA to provide covered services.

“Health care practitioner” means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.

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

~~22.~~ “Hospital” means a health care institution licensed as a hospital by the ~~Department of Health Services~~ ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

~~23.~~ “Inpatient hospital services” means a medically necessary ~~services~~ service that ~~require~~ requires an inpatient stay in an acute care hospital. ~~Inpatient~~ An inpatient hospital ~~services~~ service ~~are~~ is provided by or under the direction of a physician or other health care practitioner upon referral from a member’s primary care provider.

“Late enrollee” as specified in A.R.S. § 36-2912.04.

~~24.~~ “Life threatening” means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on ~~the~~ a patient’s condition.

~~25.~~ “Medical record” means a single, complete record kept at the site of a member’s primary care provider ~~which~~ that documents the medical services received by ~~the~~ a member, including inpatient discharge summary, outpatient care, and emergency care.

~~26.~~ “Medical services” means ~~services pertaining to medical care that are performed at the direction of a physician, on behalf of members by physicians, nurses, or other health care practitioners and technical personnel~~ health care services provided or prescribed to a member by a physician, a nurse or other health care practitioner, and technical personnel at the direction of a physician.

~~27.~~ “Medically necessary” means covered services provided by a physician or other health care practitioner within the scope of the physician’s or other health care practitioner’s practice under state law to:

a. Prevent disease, disability, and other adverse health ~~conditions~~ condition or ~~their~~ its progression; or
b. Prolong life.

~~28.~~ “Member” means an employee or a dependent who is enrolled with ~~a~~ an HCG Plan.

~~29.~~ “Noncontracting provider” means a provider who renders covered services to a member but who does not have a subcontract with the member’s HCG Plan.

“OAH” means the Office of Administrative Hearings defined in A.R.S. § 41-1092 et. seq.

~~30.~~ ~~“Other health care practitioner” means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.~~

~~31.~~ “Outpatient ~~services~~ service” means a medically necessary ~~services~~ service that may be provided in any setting on an outpatient basis ~~(~~that ~~does~~ do not require an overnight stay in an inpatient hospital~~)~~. ~~Outpatient services are~~ An outpatient service provided by or under the direction of a physician or other health care practitioner, upon referral from a member’s primary care provider.

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

~~32.~~ “Pharmaceutical ~~services~~ service” means a medically necessary ~~drugs~~ medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed ~~in accordance with~~ under ~~R9-27-207~~ 9 A.A.C. 27, Article 2.

~~33.~~ “Physician ~~services~~ service” means ~~services~~ a service provided within the scope of practice of medicine or osteopathy as defined by state law, ~~or by or under the personal supervision of an individual~~ by, or under the direction of a person licensed under state law to practice medicine or osteopathy.

~~34.~~ “Political subdivision” means the state of Arizona, ~~or~~ a county, a city, a town, or a school district within the state.

~~36.~~ “Pre-existing condition” ~~means an illness or injury that is diagnosed or treated within the 12 -month period preceding the effective date of coverage~~ as specified in A.R.S. § 36-2912.04.

“Pre-existing condition exclusion” as specified in A.R.S. § 36-2912.

~~37.~~ “Premium” means the monthly ~~prepayment~~ pre-payment submitted to HCGA by the employer group.

~~38.~~ “Pre-payment” means submission of the employer group’s premium payment 30 days in advance of the effective date of coverage ~~in accordance with~~ under ~~R9-27-306~~ 9 A.A.C. 27, Article 3.

~~39.~~ “Prescription” means an order ~~to a provider~~ for covered services for a member, ~~which~~ that is signed or transmitted by a provider licensed under applicable state law to prescribe or order the ~~services~~ service.

~~39.~~ "Primary care practitioner" means a ~~physician's~~ physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.
~~40.~~ "Primary care provider" means a ~~patient's~~ member's primary care physician or a primary care practitioner.
~~41.~~ "Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of a covered ~~services~~ service.
~~42.~~ "Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.
~~43.~~ "Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.
"Respondent" means a party responsible for the adverse action that is the subject of a grievance or request for hearing.
~~44.~~ "Rider" or "contract rider" means an amendment to the ~~group service agreement~~ GSA between an employer group and a HCG Plan.
~~45.~~ "Scope of services" means the covered, limited, and excluded services listed in ~~R9-27-201 through R9-27-210~~ 9 A.A.C. 27, Article 2.
~~46.~~ "Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.
~~47.~~ "Spouse" means ~~the~~ a husband or a wife of a HCG member who has entered into a marriage recognized as valid by Arizona.
~~48.~~ "Subcontract" means an agreement entered into by ~~a~~ an HCG Plan with any of the following:
   a. A provider of health care services who agrees to furnish covered services to members~~;~~,
   b. A marketing organization~~;~~, or
   c. Any other organization to serve the needs of the HCG Plan.
~~49.~~ "Subscriber" means an enrolled employee of an employer group.
~~50.~~ "Subscriber agreement" means a contract between an employee member and an HCG Plan.
~~51.~~ "Utilization control" means an overall accountability program encompassing quality management and utilization review.
~~52.~~ "Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.
"Waiting period" as specified in A.R.S. § 36-2912.04.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services

A. HCG Plan to provide a list of covered services. Each HCG Plan shall provide, either directly or through subcontracts, ~~the~~ a list of the covered services specified in this Article.
B. Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.
C. Scope of covered services. ~~The scope of covered services and excluded services may be further delineated or limited in the Group Service Agreement~~ An HCG Plan may further delineate, expand, or limit the scope of covered services through a rider in the GSA with prior written approval from the HCGA.

R9-27-202. Covered Services

~~**A.**~~ Covered services. Subject to the exclusions and limitations specified in these rules, the following services shall be covered by the HCG Plans:
1. Outpatient services;
2. Laboratory, radiology, and medical imaging services;
3. Prescription drugs;
4. Inpatient hospital services;
5. Emergency medical services as specified in R9-27-209 in, and out, of the service area;
6. Emergency ambulance services; ~~and~~
7. Maternity care~~.~~;
8. Cornea transplants; and
9. Kidney transplants.

~~**B.** The scope of covered services may be expanded or reduced through a rider to the group service agreement with the prior written consent of the HCGA.~~
~~**C.** Any medical service not specifically provided for in this Article or in a rider is not a covered service.~~

R9-27-203. Excluded Services

A. Excluded medical services. Any medical service not specifically provided for in this Article or in a rider is not a covered medical service.

B. Excluded services. The following services shall not be covered:

1. Services or items furnished solely for cosmetic purposes;
2. Services or items requiring prior authorization for which prior authorization has not been obtained;
3. Services or items furnished gratuitously or for which charges are not usually made;
4. Hearing aids, eye examinations for prescriptive lenses, and prescriptive lenses;
5. Long-Term care services, including nursing services;
6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director.
7. Care for health conditions that are required by state or local law to be treated in a public facility;
8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
9. Gastric stapling or diversion for weight loss;
10. Reports, evaluations, or physical examinations not required for health reasons including~~, but not limited to,~~ employment, insurance, or governmental licenses, sports, and court-ordered forensic or custodial evaluations;
11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined medically necessary by the HCG Plan Medical Director or designee. ~~to be medically necessary;~~
12. Elective abortions;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. Sex change operations and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;
18. ~~Blood, blood products;~~ Charges for administrative costs separately billed for blood and blood products;
19. ~~Human organ~~ Organ transplants ~~except for cornea and kidney transplants~~ except as specified in R9-27-202.
20. Bone marrow transplants including autologous, allogeneic-related, and allogeneic-unrelated;

~~20.~~21. Mental health services;
~~21.~~22. Durable medical equipment;
~~22.~~23. Artificial implants;
~~23.~~24. Dental services;
~~24.~~25. Transportation other than emergency ambulance services;
~~25.~~26. Psychotherapeutic drugs;
~~26.~~27. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide attempt;
~~27.~~28. Early and periodic screening, diagnosis and treatment services (EPSDT); ~~and~~
~~28.~~29. In vitro fertilization and all other fertilization treatments~~.~~;
30. Allergy testing and hyposensitization treatment; and
31. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research.

R9-27-204. Out-of-Service Area Coverage

Out-of-service area coverage. ~~In accordance with~~ As specified in R9-27-209, a ~~member's out-of-area care~~ member is ~~limited~~ entitled to ~~emergencies~~ only emergency services when ~~the member is traveling or temporarily~~ outside ~~of~~ the member's HCG ~~Plan's~~ Plan service area.

R9-27-205. Outpatient Health Services

Outpatient services. The HCG ~~Plans~~ Plan shall provide the following covered outpatient services:

1. Ambulatory surgery and anesthesiology services not specifically excluded;
2. Physician's services;
3. Pharmaceutical services and prescribed drugs to the extent authorized ~~by these rules~~ in this Article, and applicable provider contracts;
4. Laboratory services;
5. Radiology and medical imaging services;
6. Services of other health care practitioners when supervised by a physician;
7. Nursing services provided in an outpatient health care facility;
8. The use of emergency, examining, or treatment rooms when required for the provision of ~~physician's~~ physician services;

9. Home physician visits, as medically necessary;
10. Specialty care physician services referred by a primary care provider;
11. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include tasks or procedures to:
    a. Determine risk of disease~~;~~.
    b. Provide early detection of disease~~;~~.
    c. Detect the presence of injury or disease at any stage~~;~~.
    d. Establish a treatment plan for injury or disease at any stage~~;~~.
    e. Evaluate the results or progress of a treatment plan or treatment decision~~;~~. or
    f. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.
12. Short-term rehabilitation and physical therapy may be provided for a 60-day period, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.

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

A. Coverage of medically necessary laboratory, radiology and medical imaging services. ~~The HCG Plans shall provide laboratory, radiology, and medical imaging services, prescribed by the member's primary care provider, which are ordinarily provided in hospitals, clinics, physicians' offices, and other health facilities by licensed or certified health care providers, if medically necessary.~~ Medically necessary laboratory, radiology, and medical imaging services, shall be provided by a licensed or certified health care provider as prescribed by the member's primary care provider. These services shall be provided through the HCG Plan in a hospital, a clinic, a physician's office or other health facility.

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

R9-27-207. Pharmaceutical Services

A. Provision of pharmaceutical services. The HCG ~~Plans~~ Plan shall ensure that pharmaceutical services are available to members during customary business hours. The services shall be located within reasonable travel distance as determined by the HCGA within the HCG Plan's service area.

B. Limitations. The HCG ~~Plans~~ Plan shall adhere to the following limitations when providing a pharmaceutical service:
1. Drugs personally dispensed by a physician or a dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost-effective.
3. ~~Immunosuppressant (anti-rejection) drugs are covered except when prescribed as part of the post-operative treatment for noncovered organ transplants. However, if a member is taking immunosuppressant drugs at the time of enrollment as part of the post-operative treatment for any organ transplant, the drugs are not covered.~~ Members are eligible for immunosuppressant drugs only as part of the post-operative treatment for a covered kidney or cornea transplant authorized by an HCG Plan as specified in R9-27-202.
4. ~~Only drugs that are not available over-the-counter~~ Over-the-counter drugs are not covered.

R9-27-208. Inpatient Hospital Services

A. Inpatient hospital services. The HCG ~~Plans~~ Plan shall provide the following inpatient hospital services:
1. Routine services, including:
    a. Hospital accommodations;
    b. Intensive care and coronary care units;
    c. Nursing services necessary and appropriate for ~~the~~ a member's medical condition;
    d. Dietary services;
    e. Medical supplies, appliances, and equipment ~~ordinarily~~ furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;
2. Ancillary services, including:
    a. Labor, delivery, and recovery rooms, and birthing centers;
    b. Surgery and recovery rooms;
    c. Laboratory services;
    d. Radiological and medical imaging services;
    e. Anesthesiology services;
    f. Rehabilitation services;
    g. Pharmaceutical services and prescribed drugs;
    h. Respiratory therapy;
    I. Maternity services;
    j. Nursery and related services;

k. Chemotherapy; and
l. Dialysis as limited ~~by these rules~~ in this Article.

B. Limitations. The HCG Plans shall adhere to the following coverage limitations when providing inpatient hospital services:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when ~~patients~~ a patient must be isolated for medical reasons.
2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
3. Alternative levels of care instead of hospitalization are covered ~~when determined~~ if cost-effective and medically necessary as determined by the HCG ~~Plan's~~ Plan Medical Director, or designee.

R9-27-209. Emergency Medical Services

A. Emergency medical services provided within the HCG Plan's service area.
1. Emergency medical services shall be ~~available~~ provided to a ~~members~~ member 24 hours-a-day, 7 days-a-week based on the prudent layperson standard specified in 42 U.S.C. 1396u-2, August 5, 1997, which is incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. The member or provider shall notify the HCG Plan ~~within~~ no later than 24 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 24 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

B. Emergency medical services provided outside the HCG Plan's service area.
1. Emergency medical services provided outside the HCG Plan's service area ~~which cannot be postponed until the member is able to return to the service area are covered~~ is based on the prudent layperson standard as specified in 42 U.S.C. 1396u-2, August 5, 1997, incorporated by reference in subsection (A)(1).
2. The member or provider shall notify the HCG Plan ~~within~~ no later than 48 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

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

R9-27-210. Pre-existing Conditions

A. Pre-existing condition exclusions. Subject to subsection ~~(C)~~(B), ~~a~~ an HCG Plan shall not cover ~~inpatient~~ any services related to a pre-existing condition as specified in A.R.S. § 36-2912(Q) ~~for 12 months from the effective date of coverage~~.

~~**B.** A HCG Plan shall not cover inpatient costs for the delivery of a child for 10 months from the effective date of coverage.~~

~~C~~B. Failure to impose a pre-existing condition exclusion. ~~A~~ An HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of ~~their~~ birth;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a 1-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. ~~The~~ A person's prior coverage ended within ~~60~~ 63 days before the date of application for enrollment.

~~D~~C. Credit for prior health coverage. ~~A~~ An HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of 1 month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan ~~in accordance with~~ under A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan ~~which~~ that provided continuous coverage to an individual shall ~~promptly~~ disclose the coverage provided.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. Criteria for employer groups. An employer group shall conduct business within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage. ~~This shall be determined by 1 or more of the following:~~ The HCG Plan shall determine eligibility for an employer group and its employees by using 1 or more of the following documents:

1. Participation in state unemployment insurance~~;~~,
2. Participation in state worker's compensation~~;~~,
3. Possession of a state tax identification number~~;~~, ~~and~~ or
4. Other verifiable proof that the applicant is conducting a business in Arizona.

B. Amount of full time employees and enrollment. ~~An employer group other~~ Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of 1 and a maximum of ~~40~~ 50 full-time employees at the effective date of ~~it's~~ the 1st contract with a HCG Plan. Acceptable proof of the number of full-time employees may include canceled checks, bookkeeping records, and personnel ~~ledgers~~ records.

C. Required enrollment of a particular number of employees. Other than state employees and employees of political subdivisions of the state, ~~50% of the eligible employees in a group must enroll in order for the employer group to contract with a HCG Plan. Employees with proof of other medical coverage who do not wish to participate in the HCG shall not be considered in determining the percentage~~. employers with 1 to 50 eligible employees may contract with an HCG Plan if the employer:
1. Has 5 or fewer full-time employees and enrolls 100% of these employees in an HCG Plan, or
2. Has 6 or more full-time employees and enrolls 80% of these employees in an HCG Plan.

D. Employees with proof of other insurance. Employees with proof of existing health care coverage who elect not to participate in an HCG Plan shall not be considered when determining the percentage of the required number of enrollees if the health care coverage is:
1. Group coverage offered through a spouse, a parent, or a legal guardian; or
2. Coverage available from a government-subsidized health care program.

~~**D.**~~**E.** Post-enrollment changes in group size. Changes in group size that occur during the term of the ~~Group Service Agreement~~ GSA shall not affect eligibility.

F. Review and verification of eligibility determinations.
1. An HCG Plan may conduct random reviews of eligibility determinations of an employer group and its employees.
2. The HCGA may conduct random reviews of eligibility determinations completed by an HCG Plan.

R9-27-302. Eligibility Criteria for Employee Members

A. Residence. ~~Employee members~~ An employee member shall reside, work, or reside and work in Arizona.

B. Eligible employer group. ~~Employee members~~ An employee member shall be employed by an eligible employer group specified in R9-27-301.

C. Days of consecutive employment. ~~Employee members~~ An employee member shall have been employed at least 60 consecutive days before the effective date of coverage.

D. Hours of employment per week. ~~Employee members~~ An employee member or self-employed ~~persons~~ person shall work for the employer group at least ~~20~~ 32 hours per week, with anticipated employment of at least 5 months following enrollment.

R9-27-303. Eligibility Criteria for Dependents

A. Eligible dependents. ~~Eligible dependents~~ An eligible dependent of an employee ~~members~~ member shall reside in Arizona and ~~include~~ includes:
1. A legal spouse;
2. Unmarried children less than the age of 19 or less than the age of 24 if the child is a full-time student and is a:
   a. Natural child~~;~~,
   b. Adopted child~~;~~,
   c. Step-child~~;~~, or
   ~~d. Child supported by the employee member under a valid court order; and~~
   ~~e~~d. Child for whom the employee member is a legal guardian~~; and~~.
3. A child incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the HCG Plan Medical Director or designee.

B. Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements of R9-27-303(A)(2) ~~and~~ or (3).

R9-27-304. ~~Employer Group Member Eligibility Verification~~ Repealed

~~**A.** The HCG Plan shall determine the eligibility status of the employer group and members.~~

~~**B.** Eligibility verification may be conducted at random or for cause by the HCGA or HCG Plan.~~

R9-27-305. Health History Form

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

R9-27-306. Effective Date of Coverage

Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage~~;~~. ~~the~~ The effective date of coverage shall be the 1st day of the month for which the premium has been pre-paid.

R9-27-307. Open Enrollment of Employee Members

A. Open enrollment. Enrollment of an employee ~~members~~ member shall occur only during 1 of the following open enrollment periods:
1. Thirty-one days following the effective date of the ~~Group Service Agreement~~ GSA for a newly enrolled employer ~~groups~~ group;
2. A ~~30-day~~ 31-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a ~~30-day~~ 31-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; ~~and~~ or
3. A ~~30-day~~ 31-day period to begin 105 days before and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.

B. New dependent enrollment. Enrollment of new dependents shall occur: ~~within the 30-day period following the acquisition of a new dependent and in accordance with R9-27-308 if the dependent is a newborn.~~
1. Within the 31-day period following the addition of a new dependent defined in R9-27-303(A), or
2. Under R9-27-308 if the dependent is a newborn.

R9-27-308. Enrollment of Newborns

Newborn enrollment. ~~All newborns~~ A newborn shall be enrolled within 30 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA within 30 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

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

A. Enrollment of newly ~~Eligible~~ eligible employee due to loss of own coverage. An eligible employee who had health care coverage through a spouse, ~~shall be~~ is eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate health care coverage ~~was~~ is due to:
1. Death of the eligible employee's spouse~~;~~,
2. Divorce~~;~~, ~~or~~
3. Termination of employment of the eligible employee's spouse~~.~~,
4. Legal separation, or
5. Reduction in hours of employment.

B. Enrollment of newly ~~Eligible~~ eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family health care coverage separate from the member's coverage ~~and who loses that coverage due to termination of employment or retirement~~, ~~shall be~~ is eligible to enroll as a dependent member within 30 days of the loss of coverage~~.~~, if that loss of separate health care coverage is due to:
1. Death,
2. Divorce,
3. Termination of employment,
4. Legal separation,
5. Reduction in hours of employment, or
6. Retirement.

R9-27-310. Denial and Termination of Enrollment

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

B. Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month ~~in which~~ that:
1. The employer group loses eligibility~~;~~,
2. The employee member loses eligibility~~;~~, or
3. The dependent loses eligibility.

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

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

R9-27-401. General

A. Contracts to provide services. ~~Contracts to provide services under the HCG program shall be established between the HCGA and qualified HCG Plans in accordance with~~ The HCGA shall establish contracts to provide services with qualified HCG Plans as specified in ~~the applicable provisions in~~ this Article and A.R.S. Title 36, Chapter 29.

B. Contracts and subcontracts. Contracts and subcontracts entered into under this Article and on file with the HCGA are ~~shall become~~ public records ~~on file with the HCGA~~ unless otherwise made confidential by law.

R9-27-402. Contracts

A. Requirements. ~~To contract with the HCGA, a~~ A health plan must meet the requirements of A.R.S. § 36-2912 and this Article to contract with the HCGA.

B. Contract requirements. Each contract shall be in writing and ~~contain, at a minimum,~~ include the following information:

1. The method and amount of compensation or other consideration ~~to be received by the HCG Plan~~ an HCG Plan will receive;
2. ~~The name and address of the HCG Plan;~~ The HCG Plan's name and address;
3. The population and geographic service area ~~to be covered by~~ the contract will cover;
4. The amount, duration, and scope of medical services an HCG Plan will ~~to be provided~~ provide, ~~or~~ and for which compensation will be paid;
5. The term of the contract, including the beginning and ending dates, as well as methods of extension, re-negotiation, and termination;
6. A provision that the HCG Plan arrange for the collection of any required copayment, coinsurance, deductible, ~~and~~ or 3rd-party insurance;
7. A provision that the HCG Plan will not bill or attempt to collect a copayment, a coinsurance, a deductible or 3rd-party insurance from a member for any covered service except as may be authorized by statute, these rules, or contract riders that ~~have been~~ are approved by the HCGA;
8. A provision that the contract will not be assigned or transferred without the prior written approval of the HCGA;
9. Procedures for the covered population's enrollment ~~of the covered population~~;
10. Procedures and criteria for terminating or suspending the contract; ~~and~~
11. A provision that the HCG Plan will hold harmless and indemnify the state, AHCCCS, HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd-parties, ~~which~~ that may accrue against the state, AHCCCS, HCGA, or members, through the negligence or other action of the HCG Plan~~.~~; and
12. A provision that an HCG Plan demonstrate it has an adequate network of providers.

R9-27-403. Subcontracts

A. Approval. Any subcontract entered into by ~~a~~ an HCG Plan to provide covered services to an HCG Plan ~~members~~ member is subject to review and approval of the HCGA. ~~No subcontract alters~~ A provider subcontract does not alter the legal responsibility of the HCG Plan to the HCGA. The HCGA shall ~~to~~ ensure that all activities under the contract are carried out.

B. ~~Subcontracts~~ Subcontract requirements. Each subcontract shall be in writing and include:

1. A specification that the subcontract will be governed by and construed under all laws, rules, and contractual obligations of the HCG Plan~~.~~;
2. A provision that the HCG Plan will notify the HCGA in the event ~~the~~ a subcontract with ~~the~~ an HCG Plan is entered into, amended, or terminated~~.~~;
3. A provision that assignment or delegation of ~~the~~ a subcontract is void unless the HCGA gives prior written approval ~~is obtained from the HCGA.~~;
4. An agreement to hold ~~harmless~~ the state, AHCCCS, the HCGA, and members harmless in the event the HCG Plan is unable to or does not pay for covered services performed by ~~the~~ a subcontractor~~.~~;
5. A provision that the HCGA may review and give prior written approval for a subcontract and a subcontract ~~amendments~~ amendment ~~are subject to review and prior written approval by the HCGA~~ and that the HCGA may terminate, rescind, or cancel a subcontract or a contract amendment ~~a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the HCGA~~ for violation of ~~a provision of~~ these rules~~.~~;
6. An agreement to hold harmless and indemnify the state, AHCCCS, the HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd-parties, ~~which~~ that may accrue against the state, AHCCCS, the HCGA, or members, through the negligence or other action of ~~the~~ a subcontractor~~.~~;
7. The method and amount of compensation or other consideration ~~to be received by the subcontractor.~~ a subcontractor will receive; and
8. The amount, duration, and scope of medical services a subcontractor will provide ~~to be provided by the subcontractor,~~ and for which compensation will be paid.

C. Waiver of requirement to contract with hospitals. ~~A~~ An HCG Plan may submit a written request to the HCGA requesting a waiver of the requirement that the HCG Plan subcontract with a hospital in the HCG Plan's service area as specified in R9-27-402(12). The request shall state the reasons for ~~requesting~~ a waiver and all efforts ~~that have been~~ made to secure a subcontract with a hospital within the HCG Plan's service area. For good cause shown, the HCGA may waive the hospital subcontract requirement. The HCGA shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:

1. The number of hospitals in the service area;

2. The extent to which the HCG Plan's primary care providers have staff privileges at noncontracting hospitals in the service area;
3. The size and population of, and the demographic distribution within, the service area;
4. The patterns of medical practice and care within the service area;
5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area;
6. Whether the HCG Plan has any subcontracts in adjoining areas with hospitals that are reasonably accessible to the HCG Plan's members in the service area; and
7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

R9-27-404. Contract Amendments

A. Merger, reorganization, change of ownership. Any merger, reorganization, or change in ownership of ~~a~~ an HCG Plan or a subcontractor affiliated with the HCG Plan shall constitute ~~a~~ an HCGA contract amendment.
B. Written approval necessary. The HCG Plan shall obtain written approval from the HCGA, before any merger, reorganization, or change in ownership of ~~the~~ an HCG Plan or a subcontractor that is related to or affiliated with the HCG Plan.
C. Contract amendment requirements. To be effective, contract amendments shall be submitted in writing to the HCGA and executed by both parties.

R9-27-406. Continuation Coverage

Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq., December 19, 1989, incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The employer group shall collect the premium from the employee and pay the premium to HCGA.

R9-27-407. Conversion Coverage

Conversion coverage. ~~This Section~~ Conversion coverage applies only to an employee ~~members~~ member and dependents of an employer ~~groups~~ group with fewer than 20 employees.

1. An employee member, a dependent, or a qualified beneficiary who loses eligibility for a qualifying event, as defined in 29 U.S.C. 1163, and who has been covered for at least 3 months under the GSA may convert the policy to an individual policy for a period of 180 days.
2. A member shall have 30 days after the date of termination of group coverage to convert the coverage and pay the initial premium. Any ~~services~~ service used within the 30-day conversion period before payment of the initial premium ~~shall~~ is not ~~be~~ covered unless the ~~care~~ service was provided or authorized by the member's primary care provider or the HCG Plan.
3. A member shall pay the ~~premium~~ initial and subsequent premiums for the converted coverage directly to the HCGA. ~~Converted~~ Conversion coverage ~~shall be~~ is retroactive to the date of termination of group coverage.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services

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

1. ~~Have a~~ A designated emergency medical ~~services~~ service facility, providing care 24 hours-a-day, 7 days-a-week. ~~Emergency~~ An emergency medical ~~services~~ service ~~facilities~~ facility shall be accessible to members in each service area with at least 1 physician and registered nurse on call or on duty at the facility at all times.
2. ~~Have a~~ An emergency medical ~~services~~ service system employing at least 1 physician, a registered nurse, a ~~physician's~~ physician assistant, or a nurse practitioner, accessible by telephone 24 hours-a-day, 7 days-a-week, to:
   a. ~~provide~~ Provide information to providers who need verification of patient membership and treatment authorization; and
   b. ~~in the case of an emergency as defined under~~ Provide emergency medical services ~~in~~ specified in R9-27-101.
3. ~~Maintain an~~ An emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call, and
   f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical ~~services~~ service information to the member's primary care provider and other ~~appropriate organizational units~~ authorized staff.

5. An appointment system for each of the HCG Plan's service locations. The ~~appointment system~~ HCG Plan shall ensure that:
   a. ~~Members~~ A member with an acute or urgent ~~problems~~ problem ~~are~~ is triaged and provided same-day service when necessary;
   b. ~~Time-specific appointments~~ A time-specific appointment for routine medically necessary care from the primary care provider ~~are~~ is available within 3 weeks of ~~a~~ the member's request and on the same day for emergency care; and
   c. ~~Referral appointments~~ A referral appointment to ~~specialists~~ a specialist ~~are~~ is:
      i. ~~in~~ On the same day for emergency care,
      ii. ~~within~~ Within 3 days for urgent care, and
      iii. ~~within~~ Within 30 days for routine care.
6. ~~One primary~~ Primary care ~~provider~~ providers that an enrolled member may select or to whom the member may be assigned. An HCG ~~Plans~~ Plan ~~whose organization~~ that does not ordinarily include primary care providers shall enter into an affiliation or subcontract with an organization or ~~individuals~~ individual to provide primary care. The HCG ~~Plans~~ Plan shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to ~~patients~~ members;
   b. Initiating referrals for specialty care; and
   c. Maintaining continuity of ~~patient~~ member care.
7. Primary care physicians and specialists providing inpatient services to ~~members~~ a member ~~must~~ shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.

R9-27-502. Reinsurance

A. Provision of reinsurance. ~~Reinsurance may be provided by the~~ The HCGA may elect to provide reinsurance through a private ~~reinsurers~~ reinsurer.

B. Insured entity. For purposes of the HCGA's reinsurance program, the insured ~~entities~~ ~~entity~~ shall be the HCG ~~Plans~~ Plan with which the HCGA contracts.

1. The HCGA shall deduct ~~A~~ a specified amount per member, per month, ~~shall be deducted by the HCGA~~ from the HCG Plan's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

R9-27-503. Marketing, Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions

A. HCGA Plan ~~Marketing~~ marketing representatives shall not:

1. ~~misrepresent~~ Misrepresent ~~themselves,~~ the HCG Plan or the HCG program through false advertising, false statements, or in any other manner in order to induce ~~members~~ a member of ~~other~~ another contracting ~~entities~~ entity to enroll in a particular HCG Plan~~.~~;

~~**B.**~~ 2. ~~Marketing representatives shall not claim~~ Claim, infer, or ~~falsely represent themselves~~ misrepresent the HCG Plan to be employees of the state or representatives of the HCGA, a county, or ~~a~~ an HCG ~~plan~~ Plan other than the HCG Plan ~~with whom they are~~ that ~~employed~~ employs or ~~by whom they are reimbursed~~ reimburses them~~.~~; or

~~**C.**~~ 3. ~~Marketing representatives shall not engage~~ Engage in any marketing or other pre-enrollment practices that discriminate against an ~~eligible person~~ applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

~~**D.**~~**B.** HCG Plan to bear responsibility. An HCG ~~Plans~~ Plan shall bear responsibility for ~~the performance~~ any misrepresentation of any marketing representative, subcontractor or agent, program, or process under ~~their~~ its employ or direction.

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

A. Submission of marketing material. The HCG ~~Plans~~ Plan shall submit ~~to the HCGA for review and approval~~ proposed marketing strategies and marketing ~~materials~~ material in writing to the HCGA for review and approval before distributing the marketing ~~materials~~ material or implementing any ~~activities~~ marketing activity. ~~The proposed marketing strategies and materials shall be submitted in writing to the HCGA.~~

B. Review of marketing material. The HCGA shall review and approve or disapprove all proposed marketing ~~materials~~ material and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing ~~materials~~ material and marketing strategies. The notification shall include a statement of objections and recommendations.

C. Drafts. To minimize the expense of revising marketing ~~materials~~ material or other copy, ~~a~~ an HCG Plan may submit the material in draft form subject to final approval. ~~and filing of a proof or final copy.~~

D. Submission and maintenance of final copies. An HCG ~~Plans~~ Plan shall submit 2 copies of the proof or final approved copy of ~~materials~~ material to the HCGA, which shall maintain the proof or copy for 5 years.

R9-27-505. Member Records and Systems

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

R9-27-506. Fraud or Abuse

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

R9-27-509. Information to Enrolled Members

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

B. Notification of changes in services. Each HCG Plan shall prepare and distribute to members a printed member handbook insert describing any changes that the HCG Plan proposes to make in services provided within the HCG Plan's service areas. The insert shall be distributed to all affected members ~~or family units~~ and dependents at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

R9-27-510. Discrimination Prohibition

A. Discrimination. ~~A~~ HCG ~~Plan~~ Plans shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes~~, but is not limited to,~~ the following:
1. Denying a member any covered service or availability of a facility for any reason except as defined in a rider provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;
2. Providing ~~to~~ a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except ~~where~~ when medically indicated;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a ~~member in any way in the~~ member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the ~~participants~~ member to be served.

B. Provision of covered services. ~~A~~ An HCG Plan shall take affirmative action to ensure that ~~members~~ a member ~~are~~ is provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except ~~where~~ when medically indicated.

R9-27-511. Equal Opportunity

~~**A.**~~ Equal opportunity requirements. An HCG Plan shall comply with the following equal opportunity employment requirements:
1. ~~State in all solicitations or advertisements for employees placed by or on behalf of the~~ All solicitations or advertisements placed by or on behalf of an HCG Plan~~,~~ shall state that it is an equal opportunity employer~~; and~~.

2. ~~Send a notice provided by the HCGA,~~ An HCG Plan shall send a notice prepared by the HCGA to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

R9-27-512. Periodic Reports and Information

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

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

R9-27-513. Medical Audits

A. Conducting a medical audit. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan ~~approximately~~ no later than 3 weeks in advance of the date of an onsite medical review. HCGA may conduct, without prior notice, inspections an inspection of the HCG Plan ~~facilities~~ facility or perform other elements of a medical review, either in conjunction with the ~~medial~~ medical audit or as part of an unannounced inspection program.

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

1. Conduct private interviews and group conferences with:
   a. Members;
   b. Physicians and other health care practitioners;
   c. Members of the HCG Plan's administrative staff including~~, but not limited to,~~ its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include~~, but is not limited to~~:
   a. ~~The minutes~~ Minutes of medical staff meetings~~;~~,
   b. Peer review and quality-of-care review records~~;~~,
   c. Duty rosters of medical personnel~~;~~,
   d. Appointment records~~;~~,
   e. Written procedures for the internal operation of the HCG Plan~~;~~,
   f. Contracts~~;~~,
   g. Correspondence with members and ~~with~~ providers of health care services and other services to the HCG Plan~~;~~, and
   h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

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

A. Quality management and utilization review. ~~The~~ An HCG ~~Plans~~ Plan shall comply with the following quality management and utilization review requirements:

1. ~~Prepare~~ Annually prepare and submit to HCGA for review and approval a written quality management plan that includes utilization review. ~~to HCGA for review and approval annually a written quality management plan which includes utilization review~~. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems~~.~~:
   a. Ensure that a member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
   b. Ensure that medical records are maintained in a manner that:
      i. Conforms to professional medical standards and practices~~;~~,
      ii. Permits professional medical review and medical audit processes~~;~~, and
      iii. Facilitates a system for follow-up treatment.
4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
   a. Prior authorization of nonemergency hospital admissions~~;~~,
   b. Concurrent review of inpatient stays~~;~~, and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. Evaluation of utilization control system. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. ~~The~~ An HCG Plan may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

R9-27-515. Continuity of Care

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

R9-27-516. Financial Resources

A. Adequate reserves. ~~A~~ An HCG Plan shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.

B. Contract provisions. Contract provisions required by the HCGA may include~~, but are not limited to~~:
1. ~~The maintenance~~ Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

ARTICLE 6. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

R9-27-601. ~~Grievances and Appeals~~ Grievance and Request for Hearing

A. ~~The provisions of this Article provide~~ General.
1. This Article provides the exclusive manner ~~through which any individual or entity may grieve~~ for filing a grievance or request for hearing against the HCGA, the HCG Plans, or both ~~in connection with~~ for any adverse ~~action, decision, or policy.~~ action.
2. If a hearing is requested, the hearing shall be conducted under A.R.S. § 41-1092 et. seq.

~~**B.** Definitions. For the purpose of this Article:~~
~~1. "Appellant" means the individual or entity filing any grievance or appeal under this Article.~~
~~2. "Request for hearing" means an appeal of an adverse eligibility action; an appeal filed after an informal decision has been rendered on a grievance by the HCGA; an appeal of a grievance decision rendered by a HCG Plan; or an appeal filed because a HCG Plan has failed to render a timely grievance decision.~~
~~3. "Respondent" means the party responsible for the action being grieved or appealed. In most grievances, the HCG Plan is the respondent.~~

~~**C.**~~**B.** Filing ~~grievances and appeals.~~ a grievance and a request for hearing. Unless provided elsewhere in this Chapter, ~~all grievances and appeals~~ a written grievance or a request for hearing under A.R.S. § 41-1092 et. seq., or other written statements shall be considered filed when received ~~in writing~~ by the ~~HCGA.~~ HCGA, as established by the HCGA's date stamp on the grievance, request for hearing, or other written statement.

~~**D.**~~**C.** Computation of time.
1. ~~In computing any period of time for establishing timeliness of~~ Computation of time for filing ~~grievances and appeals, the period shall commence~~ a grievance begins the day after the act, event, or decision grieved ~~or appealed,~~ and ~~shall include~~ includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period ~~shall be~~ is extended until the end of the next day ~~which~~ that is not a weekend or a legal holiday.
2. Timelines for filing a request for hearing under A.R.S. § 41-1092 et. seq. is computed under R2-19-107.

D. Complainant's hearing rights. The HCGA shall allow a complainant the right to:
1. A hearing under A.R.S. § 41-1092 et. seq.; and
2. Copies of any relevant document from the respondent not protected from disclosure by law at the complainant's expense.

E. Withdrawal or denial of a request for hearing.
1. Withdrawal of a request for hearing.
   a. The HCGA shall accept a written request for withdrawal if the written request for withdrawal is received from the complainant before the HCGA or its designee issues a notice of hearing under A.R.S. § 41-1092 et. seq.
   b. If the HCGA or its designee issued a notice of hearing under A.R.S. § 41-1092 et. seq., a complainant shall send a request for withdrawal to OAH.
2. Denial of a request for hearing. The HCGA or its designee may deny a request for hearing under A.R.S. § 41-1092 et. seq. upon written determination that:

a. The request for hearing is untimely;
b. The request for hearing is not for an adverse action permitted under this Article;
c. The complainant waives the right to hearing;
d. The request for hearing is moot, as determined by HCGA or its designee based on the factual circumstances of each case;
e. The subject matter of the grievance is a policy that is not subject to OAH's jurisdiction under A.R.S. § 41-1092 et seq.; or
f. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all members.

F. Motion for rehearing or review. Under A.R.S. § 41-1092.09, the HCGA may grant a rehearing or review for any of the following reasons materially affecting a party's rights:
1. Irregularity in the proceedings of a hearing that deprived an aggrieved party of a fair hearing;
2. Misconduct of the HCGA, OAH, or a party;
3. Newly discovered material evidence, that could not, with reasonable diligence, have been discovered and produced at the hearing;
4. The decision is the result of passion or prejudice;
5. The decision is not justified by the evidence or is contrary to law; or
6. Good cause is established for the nonappearance of a party at the hearing.

~~E.~~ ~~Direct grievances to the HCGA.~~
~~1.~~ ~~A grievance may be filed directly with the HCGA only by HCG Plans or by individuals or entities grieving an adverse action, decision, or policy actually made or enacted by the HCGA. If the aggrieved adverse action, decision, or policy actually was made by a HCG Plan, the appellant shall 1st file the grievance with the HCG Plan responsible for the decision, policy or action being grieved, so that the HCG Plan may investigate and resolve the grievance in accordance with this Article and any applicable contracts.~~
~~2.~~ ~~Except as provided in subsection (E)(3), all written grievances shall be filed with and received by the HCGA not later than 35 days after the date of the adverse action, decision, or policy implementation being grieved.~~
~~3.~~ ~~Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 60 days from the date of the denial to file the grievance.~~
~~4.~~ ~~All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirements shall result in the denial of the grievance.~~
~~5.~~ ~~The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.~~
~~6.~~ ~~Pending final resolution of a grievance, appeal, or request for judicial review, a grieving HCG Plan shall proceed diligently with the performance of the contract and in accordance with the HCGA, its designee, or the Director's decision.~~
~~7.~~ ~~If a hearing is requested, it shall be conducted according to the provisions in this Article.~~

~~F.~~ ~~Grievances to HCG Plans.~~
~~1.~~ ~~Except as provided in subsection (F)(2), all grievances shall be filed with and received by the appropriate HCG Plan not later than 35 days after the date of the adverse action or decision.~~
~~2.~~ ~~Written grievances regarding claim denials shall be filed not more than 12 months after the date of the service for which payment is claimed. If the claim is denied less than 35 days before the expiration of the 12-month time period, the dissatisfied party shall have 35 days from the date of the denial to file the grievance.~~
~~3.~~ ~~All grievances shall state with particularity the factual and legal basis and the relief requested. Failure to comply with the specificity requirement shall result in the denial of the grievance.~~
~~4.~~ ~~A final decision shall be rendered by the HCG Plan on grievances that involve issues related to continuity or delivery of medical services within 15 days of filing. A final decision shall be rendered by the HCG Plan on all other grievances within 30 days of filing unless the parties agree on a longer period. The decision by the HCG Plan shall be personally delivered or mailed by certified mail to the parties, and it shall state the basis for the decision as well as the appellant's right to appeal the decision to the HCGA. The HCG Plan's final decision shall specify the manner in which an appeal to the HCGA may be filed.~~
~~5.~~ ~~The HCG Plan shall record and retain information to identify the appellant, date of receipt, and nature of the grievance.~~
~~6.~~ ~~At the time of enrollment, HCG Plans shall give to members written information regarding grievance procedures available through the HCG Plan and the HCGA.~~

~~G.~~ ~~Appeal of HCG Plan decisions to the HCGA.~~
~~1.~~ ~~After 1st grieving to the appropriate HCG Plan, an appellant may appeal to and request a hearing from the HCGA or designee if:~~

~~a. The appellant files a written notice of appeal not more than 15 days after the date of the final decision of the HCG Plan, which is the earlier of the date of personal delivery or the postmark date of certified mail; or~~

~~b. A decision is not timely rendered by the HCG Plan, and the appellant files a written notice of appeal based upon the HCG Plan's failure or refusal to timely decide the grievance.~~

~~2. The HCGA or its designee, in its sole discretion, may investigate the grievance and render a written informal decision before scheduling a hearing. A hearing shall be scheduled if any party timely requests a hearing within 15 days of the postmark date of the informal decision.~~

~~3. If a hearing is requested, it shall be conducted according to the provisions in this Article.~~

G. Grievance to the HCGA or an HCG Plan.

1. Respondent.
   a. HCGA. When grieving the HCGA's adverse action, the HCGA is the respondent.
   b. HCG Plan. When grieving an HCG Plan's adverse action, the HCG Plan is the respondent. The complainant shall file a grievance with the HCG Plan responsible for the adverse action being grieved to allow the HCG Plan to investigate and resolve the grievance.
2. Filing a grievance.
   a. Member grievance.
      i. A complainant shall file a grievance with the HCGA or an HCG Plan in writing or orally. An oral grievance shall be considered filed as of the date of the oral communication.
      ii. A complainant shall file a grievance with the HCGA or an HCG Plan no later than 60 days after the date of notice of the adverse action.
      iii. A grievance is not required to specify in detail the factual and legal basis for the grievance and the relief requested.
   b. Grievance other than a member grievance.
      i. A complainant shall file a grievance with the HCGA or an HCG Plan in writing.
      ii. A complainant shall file a grievance with the HCGA or an HCG Plan no later than 60 days after the date of notice of the adverse action except as provided in subsection (G)(2)(b)(iii).
      iii. A complainant shall file a grievance regarding a claim denial under the time-frames in A.R.S. § 36-2904.
      iv. A grievance shall specify in detail the factual and legal basis for the grievance and the relief requested. Failure to detail the factual or legal basis may result in the denial of a grievance.
3. HCG Plan's final decision of a grievance.
   a. HCG Plan's final decision. The HCG Plan shall issue its final decision of the grievance to the complainant no later than 30 days after the filing of the grievance with the HCG Plan, unless the complainant and HCG Plan agree, in writing, to a longer period.
   b. Contents of HCG Plan's final decision. The HCG Plan's final decision shall include:
      i. The date of the decision;
      ii. The factual and legal basis for the decision;
      iii. The complainant's right to request a hearing under A.R.S. § 41-1092 et. seq.; and
      iv. The manner in which a request for hearing may be filed under A.R.S. § 41-1092 et. seq.
   c. Request for hearing of HCG Plan's final decision of grievance. A complainant may request a hearing under A.R.S. § 41-1092 et. seq. on the HCG Plan's final decision of the grievance if:
      i. The complainant files a written request for hearing with the HCGA no later than 30 days after the date of the HCG Plan's final decision of the grievance; or
      ii. A final decision of the grievance under subsection (G)(3)(a) is not rendered by the HCG Plan within 30 days after the filing of the grievance with the HCG Plan, and the complainant files a written request for hearing under A.R.S. § 41-1092 et. seq. based on the HCG Plan's failure or refusal to decide the grievance.
4. HCGA's final decision of grievance.
   a. HCGA's final decision. The HCGA or its designee shall:
      i. Issue its final decision of the grievance to the complainant no later than 30 days after the filing of the grievance with the HCGA, unless the complainant and HCGA agree, in writing, to a longer period; or
      ii. Issue a notice of hearing under A.R.S. § 41-1092.03.
   b. Contents of HCGA's final decision. The HCGA's final decision shall include:
      i. The date of the decision;
      ii. The factual and legal basis for the decision;
      iii. The complainant's right to request a hearing under A.R.S. § 41-1092 et. seq.; and
      iv. The manner in which a request for hearing may be filed under A.R.S. § 41-1092 et. seq.
   c. Request for hearing of HCGA's final decision of grievance. A complainant may request a hearing under A.R.S. § 41-1092 et. seq. on the HCGA's final decision of the grievance if:
      i. The complainant files a written request for hearing with the HCGA no later than 30 days after the date of the HCGA's final decision of the grievance; or

ii. A final decision of the grievance under subsection (G)(4)(a) is not rendered by the HCGA within 30 days after the filing of the grievance with the HCGA, and the complainant files a written request for hearing with the HCGA based on the HCGA's failure or refusal to decide the grievance.

5. Notice of hearing. The HCGA shall issue a notice of hearing under A.R.S. § 41-1092.05 if the HCGA or an HCG Plan receives a timely request for hearing after the HCGA or a HCG Plan issues its final decision of grievance.

~~H. Appellant's hearing rights. The Administration shall afford an appellant the right to:~~
~~1. Have a hearing that is conducted as specified in A.R.S. §§ 41-1061 and 41-1062.~~
~~2. Obtain copies of any relevant documents from the respondent or from the HCGA at the appellant's expense.~~
~~3. Appear at the hearing and be heard in person, by telephone if available, through a representative designated in writing by the appellant, or to submit to the HCGA a written statement that is signed and notarized before the hearing.~~
~~4. Bring an interpreter to assist at the hearing.~~
~~5. Be provided an interpreter by the Administration if hearing-challenged according to A.R.S. § 12-242.~~

~~I. Withdrawal or denial of a request for hearing.~~
~~1. The HCGA or designee shall deny a request for hearing and deny a grievance or appeal if a written request for withdrawal is received from the appellant before the date of the hearing. The case file shall then be closed.~~
~~2. The HCGA or designee may deny a request for hearing and dismiss a grievance or appeal upon written determination if:~~
~~a. The request for hearing is untimely;~~
~~b. The request for hearing, grievance, or appeal is not for a reason permitted under this Article; or~~
~~c. The appeal is otherwise moot.~~

~~J. Notice of Hearing. The Notice of Hearing shall be in accordance with A.R.S. § 41-1061 and shall include a statement detailing how an appellant may request a change in the scheduled hearing date.~~

~~K. Postponement.~~
~~1. The HCGA or designee's own motion may postpone a hearing. When a request for postponement is made by a party, it shall be in writing and received by the HCGA or designee no later than 5 days before the scheduled hearing date. The HCGA or designee may grant a request for postponement on a showing that:~~
~~a. There is good cause for the postponement; and~~
~~b. The cause is beyond the reasonable control of the party making the request.~~
~~2. If a postponement is granted, the hearing shall be rescheduled at the earliest practicable date.~~

~~L. Failure to appear for hearing. If any party or representative fails to appear at the hearing without good cause or a postponement, the HCGA or designee may:~~
~~1. Proceed with the hearing;~~
~~2. Reschedule the hearing with further notice;~~
~~3. Issue a decision based on the evidence of record; or~~
~~4. Issue a default disposition.~~

~~M. Conduct hearing. The hearing shall be conducted as specified in A.R.S. §§ 41-1061 and 41-1062.~~
~~1. The hearing shall be conducted in an informal manner without formal rules of evidence or procedure.~~
~~2. The HCGA or designee may:~~
~~a. Hold prehearing conferences to settle, simplify, or identify issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding;~~
~~b. Require parties to state their positions concerning the various issues in the proceeding;~~
~~c. Require parties to produce for examination those relevant witnesses and documents under their control;~~
~~d. Rule on motions and other procedural items;~~
~~e. Regulate the course of the hearing and conduct of participants;~~
~~f. Establish time limits for submission of motions or memoranda;~~
~~g. Impose appropriate sanctions against any individual failing to obey an order under these procedures, which may include:~~
~~i. Refusing to allow the individual to assert or oppose designated claims or defenses, or prohibiting that individual from introducing designated matters in evidence;~~
~~ii. Excluding all testimony of an unresponsive or evasive witness; and~~
~~iii. Expelling the individual from further participation in the hearing.~~
~~h. Take official notice of any material fact not appearing in evidence in the record, if the fact is among the traditional matter of judicial notice; and~~
~~i. Administer oaths or affirmations.~~

~~N. Recommended decision. After the conclusion of the hearing, unless the appellant withdraws or the parties stipulate to a settlement, the hearing officer of the HCGA or designee shall prepare written findings of fact and conclusions of law and render a recommended decision to the Director.~~

~~O. Decision of the Director.~~

~~1. The Director may affirm, modify, or reject the recommended decision in whole or in part; may remand a matter to any party or the hearing officer with specific instructions; or make any other appropriate disposition.~~

~~2. The Director shall mail by certified mail a copy of the decision to all parties at their last known residences or places of business.~~

~~**P.** Petition for rehearing or review.~~

~~1. A party dissatisfied with the decision may petition the Director for rehearing or review of the decision for any of the following causes which materially affects the appellant's rights:~~

~~a. Irregularity in the proceedings of the hearing or appeal that caused the aggrieved party to be deprived of a fair hearing or appeal;~~

~~b. Misconduct of a party or the HCGA;~~

~~c. Newly discovered material evidence, which with reasonable diligence could not have been discovered and produced at the hearing;~~

~~d. That the decision is the result of passion or prejudice; or~~

~~e. That the decision is not justified by the evidence or is contrary to law.~~

~~2. The petition for rehearing or review shall be filed not later than 15 days after the date of the Director's decision, which is the postmark date of the decision. The moving party shall also send a copy of the petition to all other parties. If a timely petition for rehearing or review is filed, the Director's decision is not a final administrative decision; rather, the Director shall render a final decision which is the final administrative decision.~~

~~3. The petition for rehearing or review shall be in writing and shall specifically state the grounds upon which it is based. The Director shall review the sufficiency of the evidence if the petition is made upon the ground that the decision is not justified by the evidence.~~

~~4. The Director may remand the case to any party; reopen the decision; order the taking of additional testimony or evidence before the hearing officer; amend findings of fact and conclusions of law; make new findings and conclusions; render an amended decision; or deny the petition and affirm the previous decision.~~

~~5. The Director, within the time for filing a petition for rehearing or review, may on the Director's own motion order a rehearing or issue an amended decision for any reason for which the Director might have done so upon petition of any party.~~

~~**Q.** Failure to submit a grievance, appeal, request for hearing, or petition for rehearing or review in a timely manner shall constitute a failure to exhaust administrative remedies required as a condition to seeking judicial relief.~~

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. ~~Scope of the HCGA's~~ HCGA Liability; Payments to HCG Plans

A. Liability for covered services. The HCGA ~~shall bear~~ is ~~no~~ not ~~liability~~ liable for the provision of covered services or the completion of a plan of treatment ~~to~~ for any member.

~~**B.** All payments to HCG Plans shall be made under the terms and conditions of contracts executed between the HCG Plan and HCGA in accordance with these rules.~~

~~C.~~B. Liability for subcontracts. ~~The HCGA shall bear no liability for subcontracts that the HCG Plan executes with other parties for the provision of either administrative or management services, medical services, covered health care services, or for any other purpose. The HCG Plan shall indemnify and hold the HCGA harmless from any and all liability arising from the HCG Plan's subcontracts. The HCG Plan shall bear all costs of defense of any litigation over liability and shall satisfy in full any judgment entered against the HCGA arising from a HCG Plan subcontract. All deposits, bonds, reserves, and security posted under R9-27-516 shall be held by the HCGA to satisfy the obligations of this Section.~~

1. The HCGA is not liable for subcontracts that the HCG Plan executes for the provision of:
   a. Administrative or management services,
   b. Medical services,
   c. Covered health care services, or
   d. For any other purpose.
2. Each HCG Plan shall indemnify and hold the HCGA harmless from:
   a. Any and all liability arising from the HCG Plan's subcontracts,
   b. All judgment and injunctive costs of defense of any litigation for liability,
   c. Satisfy any judgment entered against the HCGA arising from an HCG Plan subcontract.
3. All deposits, bonds, reserves, and security posted under R9-27-516 are forfeited to the HCGA to satisfy any obligations of this Section.

C. Payments. All payments to an HCG Plan shall be made under the terms and conditions of the contract executed between the HCG Plan and HCGA as specified in this Article.

D. Premiums. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to ~~those~~ an HCG ~~Plans~~ Plan that ~~have~~ has either posted ~~required~~ a performance ~~bonds~~ bond or ~~have~~ has otherwise provided sufficient security to the HCGA.

R9-27-702. Prohibition Against Charges to Members

Prohibition against charges to members. ~~No~~ An HCG Plan, subcontractor, noncontracting provider, or nonprovider reimbursed by a HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that ~~the~~ a member willfully withheld information pertaining to the member's enrollment in ~~a~~ an HCG Plan. An HCG ~~Plans~~ Plan shall have the right to recover from a member that portion of payment made by a 3rd-party to ~~the~~ a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.

R9-27-703. Payments by HCG Plans

A. Payment for covered services. ~~A~~ An HCG Plan shall pay the provider for all covered services rendered to the HCG Plan's ~~members~~ member if the services were arranged by the HCG Plan's ~~agents~~ agent or ~~the HCG Plan's employees~~ employee, subcontracting ~~providers~~ provider, or other ~~individuals~~ individual acting on behalf of the HCG Plan. ~~and if necessary authorization was obtained.~~

B. Payment for medically necessary outpatient services. ~~A~~ An HCG Plan shall reimburse a subcontracting ~~providers~~ provider ~~and~~ or noncontracting ~~providers~~ provider for covered health care services provided to the HCG ~~Plan's~~ Plan ~~members~~ member. Reimbursement shall be made within the time period specified by contract between ~~a~~ an HCG Plan and a subcontracting ~~entity~~ provider or noncontracting provider or within 60 days of receipt of a clean claim, if a time period is not specified.

C. Payment for in-state inpatient and outpatient hospital services including emergency services.

1. An HCG ~~Plans~~ Plan shall reimburse an in-state subcontracting ~~providers~~ provider for the provision of inpatient ~~and~~ or outpatient hospital services, including emergency services~~,~~ specified in R9-27-209 at the subcontracted rate.
2. An HCG ~~Plans~~ Plan shall reimburse an in-state noncontracting ~~providers~~ provider for the provision of inpatient ~~and~~ or outpatient hospital services, including emergency services specified in R9-27-209, ~~in accordance with~~ according to the reimbursement methodology ~~stipulated~~ stated in A.R.S. § 36-2903.01(J).

D. ~~1.~~ Payment for emergency services. An HCG ~~Plans~~ Plan shall pay for all emergency care services rendered ~~their~~ to the HCG Plan ~~members~~ member by a noncontracting ~~providers~~ provider if the services:

~~a.~~1. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and

~~b.~~2. Conform to the notification requirements in Article 2 of these rules.

~~2. HCG Plans shall provide written notice to providers whose claims are denied or reduced by the HCG Plan within 30 days of adjudication of the claims. This notice shall include a statement describing the provider's right to:~~

~~a. Grieve the HCG Plan's rejection or reduction of the claim; and~~

~~b. Submit a grievance to the HCGA, or its designee under Article 6 of these rules.~~

~~**D.**~~**E.** Payment for out-of-state inpatient and outpatient hospital services. ~~The~~ An HCG ~~Plans~~ Plan shall reimburse an out-of-state subcontracting ~~providers~~ provider at the subcontracted rate. ~~The~~ An HCG ~~Plans~~ Plan shall reimburse an out-of-state noncontracting ~~providers~~ provider for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.

~~**E.**~~**F.** Payment for emergency ambulance services. ~~The~~ An HCG ~~Plans~~ Plan shall reimburse an out-of-state subcontracting ~~providers~~ provider at the subcontracted rate. ~~The~~ An HCG ~~Plans~~ Plan shall reimburse a noncontracting ~~providers~~ provider for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

G. Nonpayment of a claim. In the absence of a contract with an HCG Plan, an HCG Plan is not required to pay a claim for a covered service that is submitted more than 6 months after the date of the service or that is submitted as a clean claim more than 12 months after the date of service.

H. Notice of a denied claim. An HCG Plan shall provide written notice to a provider whose claim is denied or reduced by an HCG Plan within 30 days of adjudication of the claim. This notice shall include a statement describing the provider's right to:

1. Grieve the HCG Plan's rejection or reduction of the claim; and
2. Submit a grievance to the HCGA, or its designee under 9 A.A.C. 27, Article 6.

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

A. Liability to noncontracting and nonprovider hospitals. ~~For purposes of~~ An HCG Plan ~~liability, an~~ is liable for reimbursement for a member's emergency medical condition: ~~shall be subject to reimbursement only until the time the member's condition is stabilized and the member is transferable to a subcontractor, or until the member is discharged following stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.~~

1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or
2. Until the member is discharged post-stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Liability when transfer of member is not possible. Subject to subsection (A) Subject to the provisions of subsection (A), if a member cannot be transferred following stabilization for post-stabilization services to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay the provider for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer. The reimbursement is at the lower of a negotiated discounted rate or prospective tiered-per-diem rate.

C. Member refusal of transfer. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:

1. Subsequent to After consultation with the member's HCG Plan, the member continues to refuse the transfer; and
2. The member has been is provided and signs a written statement of liability, before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

R9-27-705. Copayments

A. Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.

B. Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:

1. The impact the amount of the copayment will have on the population served;, and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. Copayment provisions. The HCGA shall include the copayment provisions in it's the contract with a an HCG Plan.

D. Schedule of copayments. The An HCG Plans Plan shall provide a schedule of the copayments to members at the time of enrollment.

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. Priority of Benefit Payment

A. HCG Plans shall coordinate all 3rd-party benefits. Services provided under the HCG Plan are not intended to duplicate other services and benefits available to an employee member.

B. Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment 1st.
2. If a member is covered by another plan or policy which that has coordination of coordinates benefits:
   a. The plan that provided provides or authorized authorizes the service shall make payment 1st.
   b. A plan, that is not other than a prepaid plan, that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
3. If coverage is provided to a dependent child and both parents have family coverage:
   a. The plan of the employee whose birthday occurs 1st in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.
   b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay 1st.
   c. If 1 of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
   a. The plan of the employee with custody of the child shall pay 1st;
   b. The plan of the spouse of the employee with custody of the child shall pay 2nd; and
   c. The plan of the employee not having custody of the child shall pay last.

C. Primary payors. An HCG Plans Plan shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

D. Lien and subrogation rights. An HCG Plans Plan shall not have lien or subrogation rights beyond those held by health care services organizations licensed under A.R.S. § Title 20, Chapter 4, Article 9.

NOTICE OF FINAL 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**

Sections Affected	Rulemaking Action
R9-28-101	Amend
R9-28-108	Amend
Article 8	Amend
R9-28-801	Repeal
R9-28-801	New Section
R9-28-802	Repeal
R9-28 802	New Section
R9-28-803	Repeal
R9-28-803	New Section
R9-28-1108	Amend
Article 12	Amend
R9-28-1201	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(I)(1)

Implementing statutes: A.R.S. §§ 36-2932(I)(1) and 41-1092.02 et. seq

3. The effective date of the rules:

August 7, 2000

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 660, February 11, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 1376, April 14, 2000

5. 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, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

The Administration amended 4 Articles in 9 A.A.C. 28 to comply with changes to state statute. The changes were implemented on July 1, 1999, when the hearing process moved from the AHCCCS Administration to the Office of Administrative Hearings (OAH). In addition, whenever possible, the language was cross-referenced to 9 A.A.C. 22 to streamline and enhance the uniformity of rule language.

7. Reference to any study that the agency relied on in its evaluation of or justification for the 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

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

Not applicable

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

The AHCCCS Administration and the Office of Administrative Hearings (OAH) will benefit from the changes, which clarify their roles in the grievance and request for hearing process and comply with changes to state statute.

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

#	Subsection	Change
1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, and punctuation changes throughout the rules.
2.	R9-28-101	The Administration added a definition of "Director" to clarify that Director means the Director of the Administration or the Director's designee and to make the rules more clear, concise, and understandable.
3.	R9-28-803(B)	The Administration amended the language to make it more clear, concise, and easy to understand.

11. A summary of the principal comments and the agency response to them:

The Administration conducted a videoconference public hearing in Phoenix, Flagstaff, and Tucson, Arizona and an additional public hearing in Casa Grande, Arizona on May 16 and 17, 2000. No one attended either public hearing.

Before the close of record, 5:00 p.m., Wednesday, May 17, 2000, the Administration received written comments from Phoenix Health Plan.

Phoenix Health Plan requested clarification of R9-28-803 – adverse eligibility actions. The Administration clarified the language to make it more clear, concise, and easy to understand. The Administration conducted a conference call with Phoenix Health Plan to discuss their comments.

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

Not applicable

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

None

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

No

15. 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

Sections
R9-28-101. General Definitions
R9-28-108. Grievance and ~~Appeal~~ Request for Hearing Related Definitions

ARTICLE 8. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

Sections
~~R9-28-801.~~ ~~General Provisions for All Grievances and Appeals~~ Repealed
R9-28-801. General Provisions for a Grievance and a Request for Hearing
~~R9-28-802.~~ ~~Eligibility Appeals and Hearing Requests for Applicant or Recipients of ALTCS~~ Repealed
R9-28 802. Grievance
~~R9-28-803.~~ ~~Grievances~~ Repealed
R9-28-803. Eligibility Hearing for an Applicant or a Member Under 9 A.A.C. 28, Article 4

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Section
R9-28-1108. Grievance and ~~Appeal~~ Request for Hearing Process

ARTICLE 12. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

Section
R9-28-1201. Rights and Responsibilities for Expedited Hearings

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
"211"	42 CFR 435.211
"217"	42 CFR 435.217
"236"	42 CFR 435.236
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-28-111
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
~~"AHCCCS hearing officer"~~	~~R9-22-108~~
"Algorithm"	R9-28-104
"ALTCS"	A.R.S. § 36-2932
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102
~~"Appeal"~~	~~R9-22-108~~
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-28-111
"Behavioral health paraprofessional"	R9-28-111
"Behavioral health professional"	R9-28-111
"Behavioral health service"	R9-28-111
"Behavioral health technician"	R9-28-111
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	R9-28-111
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case management services"	R9-28-111
"Case manager"	R9-28-101
"Case record"	R9-22-101
~~"Categorically eligible"~~ "Categorically-eligible"	A.R.S. § 36-2934
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-28-111
"CFR"	R9-28-101
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-28-111
"Community Spouse"	R9-28-104
"Contract"	R9-22-101
"Contractor"	R9-22-101
"County of fiscal responsibility"	R9-28-107
"Covered services"	R9-22-102
"CPT"	R9-22-107
"CSRD"	R9-28-104
"Day"	R9-22-101
"DES Division of Developmental Disabilities"	A.R.S. § 36-551
"De novo hearing"	R9-28-111
"Developmental disability"	A.R.S. § 36-551
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	R9-22-102
"Eligible person"	A.R.S. § 36-2931
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Estate"	A.R.S. § 14-1201
"Evaluation"	R9-28-111

Term	Reference
“Facility”	R9-22-101
“Factor”	R9-22-101
“Fair consideration”	R9-28-104
“FBR”	R9-22-101
“Grievance”	R9-22-108
“GSA”	R9-22-101
“Guardian”	R9-22-116
“HCBS”	A.R.S. §§ 36-2931 and 36-2939
“Hearing”	R9-22-108
“Home”	R9-28-101
“Home health services”	R9-22-102
“Hospital”	R9-22-101
“ICF-MR”	42 CFR 435.1009 and 440.150
“IHS”	R9-28-101
“IMD”	42 CFR 435.1009
“Indian”	P.L. 94-437
“Inpatient psychiatric facilities for individuals under age 21”	R9-28-111
“Institutionalized”	R9-28-104
“Interested Party”	R9-28-106
“JCAHO”	R9-28-101
“License” or “licensure”	R9-22-101
“Medical record”	R9-22-101
“Medical services”	R9-22-101
“Medical supplies”	R9-22-102
“Medically eligible”	R9-28-104
“Medically necessary”	R9-22-101
“Member”	A.R.S. § 36-2931
“Mental disorder”	R9-28-111
“MMMNA”	R9-28-104
“NF”	42 U.S.C. 1396r(a)
“Noncontracting provider”	A.R.S. § 36-2931
“Occupational therapy”	R9-22-102
“Partial care”	R9-28-111
“PAS”	R9-28-103
“PASARR”	R9-28-103
“Pharmaceutical service”	R9-22-102
“Physical therapy”	R9-22-102
“Physician”	R9-22-102
“Post-stabilization services”	42 CFR 438.114
“Practitioner”	R9-22-102
“Primary care provider”	R9-22-102
“Primary care provider services”	R9-22-102
“Prior authorization”	R9-22-102
“Prior period coverage”	R9-28-101
“Prior-quarter period”	R9-28-101
“Private duty nursing services”	R9-22-102
“Program contractor”	A.R.S. § 36-2931
“Provider”	A.R.S. § 36-2931
“Prudent layperson standard”	42 U.S.C. 1396u-2
“Psychiatrist”	R9-28-111
“Psychologist”	R9-28-111
“Psychosocial rehabilitation”	R9-28-111
“Quality management”	R9-22-105
“RBHA”	R9-28-111
“Radiology”	R9-22-102
“Reassessment”	R9-28-103
“Redetermination”	R9-28-104
“Referral”	R9-22-101
“Reinsurance”	R9-22-101

“Representative”	R9-28-104
“Respiratory therapy”	R9-22-102
“Respite care”	R9-28-102
“RFP”	R9-22-106
“Room and board”	R9-28-102
“Scope of services”	R9-22-102
“Screening”	R9-28-111
“Speech therapy”	R9-22-102
“Spouse”	R9-28-104
“SSA”	P.L. 103-296, Title I
“SSI”	R9-22-101
“Subcontract”	R9-22-101
“Substance abuse”	R9-28-111
“Treatment”	R9-28-111
“Utilization management”	R9-22-105
“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:

“AHCCCS” is defined in 9 A.A.C. 22, Article 1.

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

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

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; 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; 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; 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.

“Capped fee-for-service” is defined in 9 A.A.C. 22, Article 1.

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

“Case manager” means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of 2 years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

“Case record” is defined in 9 A.A.C. 22, Article 1.

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

“Contract” is defined in 9 A.A.C. 22, Article 1.

“Day” is defined in 9 A.A.C. 22, Article 1.

“DES Division of Developmental Disabilities” is defined in A.R.S. § 36-551.

“Director” is defined in 9 A.A.C. 22, Article 1.

“Disenrollment” is defined in 9 A.A.C. 22, Article 1.

“Eligible person” is defined in A.R.S. § 36-2931.

“Enrollment” is defined in 9 A.A.C. 22, Article 1.

“Facility” is defined in 9 A.A.C. 22, Article 1.

“Factor” is defined in 9 A.A.C. 22, Article 1.

“FBR” means Federal Benefit Rate and is defined in 9 A.A.C. 22, Article 1.

"HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.
"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.

"Hospital" is defined in 9 A.A.C. 22, Article 1.
"GSA" is defined in 9 A.A.C. 22, Article 1.
"ICF-MR" means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.
"IHS" means the Indian Health Services.
"Indian" is defined in P.L. 94-437.
"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.
"License" or "licensure" is defined in 9 A.A.C. 22, Article 1.
"Medical record" is defined in 9 A.A.C. 22, Article 1.
"Medical services" is defined in 9 A.A.C. 22, Article 1.
"Medically necessary" is defined in 9 A.A.C. 22, Article 1.
"Member" is defined in A.R.S. § 36-2931.
"NF" means nursing facility and is defined in 42 U.S.C. 1396r(a).
"Noncontracting provider" is defined in A.R.S. § 36-2931.
"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.
"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.
"Program contractor" is defined in A.R.S. § 36-2931.
"Provider" is defined in A.R.S. § 36-2931.
"Referral" is defined in 9 A.A.C. 22, Article 1.
"Reinsurance" is defined in 9 A.A.C. 22, Article 1.
"SSA" means Social Security Administration defined in P.L. 103-296, Title I.
"SSI" is defined in 9 A.A.C. 22, Article 1.
"Subcontract" is defined in 9 A.A.C. 22, Article 1.

R9-28-108. Grievance and ~~Appeal~~ Request for Hearing 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.~~ ~~"AHCCCS hearing officer" is defined in 9 A.A.C. 22, Article 1.~~
~~2.~~ ~~"Appeal" is defined in 9 A.A.C. 22, Article 1.~~
~~3.~~ "Grievance" is defined in 9 A.A.C. 22, Article 1.
"Hearing" is defined in 9 A.A.C. 22, Article 1.

ARTICLE 8. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

~~R9-28-801.~~ ~~General Provisions for All Grievances and Appeals~~ Repealed

~~All grievances and appeals regarding ALTCS shall be filed and processed in accordance with A.A.C. R9-22-801, and all references in that rule to AHCCCS also shall apply to ALTCS. In eligibility appeals, ALTCS is the respondent.~~

R9-28-801. General Provisions for a Grievance and a Request for Hearing

A grievance and a request for hearing under this Chapter shall comply with A.A.C. R9-22-801.

~~R9-28-802.~~ ~~Eligibility Appeals and Hearing Requests for Applicant or Recipients of ALTCS~~ Repealed

~~A.~~ ~~Adverse eligibility actions. An applicant, eligible person, or member may appeal and request a hearing concerning any of the following adverse eligibility actions:~~

~~1.~~ ~~Denial of eligibility;~~
~~2.~~ ~~Discontinuance of eligibility;~~
~~3.~~ ~~Delay in the eligibility determination;~~
~~4.~~ ~~Adverse post-eligibility treatment of income; or~~
~~5.~~ ~~Adverse disability determination.~~

~~B.~~ ~~The Administration shall provide notice of an adverse eligibility action to the affected individual by personal delivery or regular mail. For purposes of this Section, the date of the Notice of Adverse eligibility action shall be the date of personal delivery to the individual or the postmark date, if mailed.~~

~~C.~~ ~~Appeals and requests for hearing.~~

~~1.~~ ~~An applicant, eligible person, member, or authorized representative may appeal and request a hearing regarding any adverse eligibility action by completing and submitting the ALTCS Request for Hearing form or by submitting a written request containing the following information:~~

~~a.~~ ~~The case name,~~

~~b.~~ ~~The adverse eligibility action being appealed, and~~

~~c.~~ ~~The reason for appeal.~~

~~2.~~ ~~The request for hearing shall be submitted within 20 days of a notice of denial or 10 days after the effective date of all other adverse actions by mailing or delivering it to either the eligibility office that rendered the adverse decision or directly to the Administration, Office of Grievance and Appeals. For this Section only, the date of the request for hearing shall be the postmark date, if mailed, or the date of personal delivery.~~

~~D.~~ ~~Eligibility office responsibilities.~~

~~1.~~ ~~Eligibility offices shall maintain a register that documents the dates on which ALTCS Requests for Hearing are submitted.~~

~~2.~~ ~~If requested, an eligibility office shall help an appellant or authorized representative to complete the ALTCS Request for Hearing form.~~

~~3.~~ ~~basis for the adverse eligibility action.~~

~~4.~~ ~~The eligibility office shall send to the Administration, Office of Grievance and Appeals:~~

~~a.~~ ~~The prehearing summary;~~

~~b.~~ ~~A copy of the case file;~~

~~c.~~ ~~Documents pertinent to the adverse action; and~~

~~d.~~ ~~The request for hearing. These materials must be received by the Administration, Office of Grievance and Appeals, not later than 10 days from the date of the receipt of the request for hearing. If the request for hearing is submitted directly to the Administration, Office of Grievance and Appeals, the eligibility office shall send the materials to the Office of Grievance and Appeals, not later than 10 days from the date of a request for the materials.~~

~~E.~~ ~~ALTCS coverage during the appeal process.~~

~~1.~~ ~~Eligible persons or members appealing a discontinuance. A discontinuance is a termination of ALTCS benefits. For actions requiring 10 days' advance notice, an eligible person or member requesting a hearing before the effective date of the adverse action shall receive continued ALTCS benefits until an adverse decision on appeal is rendered.~~

~~2.~~ ~~Applicants appealing a denial of ALTCS coverage:~~

~~a.~~ ~~A denial is an adverse eligibility decision that finds an applicant ineligible for ALTCS benefits.~~

~~b.~~ ~~An applicant may appeal a denial within the time-frame specified in subsection (C)(2). If the denial is overturned, the effective date of ALTCS coverage shall be established by the Director in accordance with applicable law.~~

~~3.~~ ~~An eligible person or member whose benefits are continued under subsection (E)(1) may be financially liable for all ALTCS benefits received during a period of ineligibility, if a discontinuance decision is upheld by the Director.~~

R9-28-802. Grievance

A grievance and request for hearing under this Chapter shall comply with R9-22-802.

~~R9-28-803.~~ ~~Grievances~~ Repealed

~~All grievances regarding ALTCS shall be filed and processed in accordance with A.A.C. R9-22-804, and all references in that rule to AHCCCS also shall apply to ALTCS.~~

R9-28-803. Eligibility Hearing for an Applicant or a Member Under 9 A.A.C. 28, Article 4

A. General. Except as provided in this Section, an eligibility hearing for an applicant or a member under this Chapter shall comply with R9-22-803.

B. Adverse eligibility actions. An applicant or member may request a hearing under A.R.S. § 41-1092 et. seq. regarding:

1. An adverse eligibility action specified in R9-22-803; or
2. An increase in the member's post-eligibility treatment of income (share-of-cost). When the request for hearing under A.R.S. § 41-1092 et. seq. is filed before the effective date of the increased share-of-cost, the share-of-cost shall not be increased until a final administrative decision is rendered under A.R.S. § 41-1092.08.

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

R9-28-1108. Grievance and ~~Appeal~~ Request for Hearing Process

A. Processing ~~of~~ a grievance. ~~All grievances regarding any~~ A grievance for an adverse ~~action, decision, or policy regarding~~ action for a behavioral health ~~services~~ service shall be ~~reviewed according to~~ processed s specified in 9 A.A.C. 28, Articles 8 and 12 and under A.R.S. §§ 36-2932, 36-3413, ~~41-1092.02, 9 A.A.C. 28, Article 8, and 9 A.A.C. 28, Article 12.~~ and 41-1092 et. seq. The grievance and request for hearing process is illustrated in 9 A.A.C. 22, Article 8, Exhibit A.

B. Member ~~appeal.~~ request for hearing. A member's ~~appeal of~~ request for hearing for a grievance under this Article shall be conducted ~~as a contested case as specified in~~ under 9 A.A.C. 28, Article 8.

~~**C.** Other appeals. An appeal of the Director's decision after an Office of Administrative Hearing decision other than de novo hearing requests by a member shall be limited to an appellate review by the Administration to determine whether substantial evidence in the record supports the decision.~~

ARTICLE 12. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

R9-28-1201. Rights and Responsibilities for Expedited Hearings

The Administration and its contractors shall ~~meet~~ comply with the requirements ~~specified~~ in 9 A.A.C. 22, Article 13.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM QUALIFIED MEDICARE BENEFICIARY (QMB)

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
R9-29-101	Amend
Article 5	Amend
R9-29-501	Repeal
R9-29-501	New Section
R9-29-502	Repeal
R9-29-502	New Section
R9-29-503	Repeal
R9-29-503	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. § 36-2972(B)

Implementing statutes: A.R.S. §§ 36-2903.01 and 41-1092.02 et. seq

3. The effective date of the rules:

August 7, 2000

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

Notice of Rulemaking Docket Opening: 6 A.A.R. 661, February 11, 2000

Notice of Proposed Rulemaking: 6 A.A.R. 1384, April 14, 2000

5. 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, Arizona 85034

Telephone: (602) 417-4198

Fax: (602) 256-6756

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

The Administration amended 9 A.A.C. 29, Articles 1 and 5 to comply with changes to state statute. The changes were implemented on July 1, 1999, when the hearing process moved from AHCCCS to the Office of Administrative Hearings (OAH). In addition, whenever possible, the language was cross-referenced to 9 A.A.C. 22 to streamline and enhance the uniformity of rule language.

7. Reference to any study that the agency relied on in its evaluation of or justification for the 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

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

Not applicable

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

AHCCCS and the Office of Administrative Hearings (OAH) will benefit from the changes, which clarify their roles in the grievance and request for hearing process and comply with changes to state statute.

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

#	Subsection	Change
1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, and punctuation changes throughout the rules.
2.	R9-29-101	The Administration added a definition of "Director" to clarify that Director means the Director of the Administration or the Director's designee and to make the rules more clear, concise, and understandable.

11. A summary of the principal comments and the agency response to them:

The Administration conducted a videoconference public hearing in Phoenix, Flagstaff, and Tucson, Arizona and an additional public hearing in Casa Grande, Arizona on May 16 and 17, 2000. No one attended either public hearing. The Administration received no written comments before the close of record, 5:00 p.m., Wednesday, May 17, 2000.

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

Not applicable

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

None

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

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 29. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM QUALIFIED MEDICARE BENEFICIARY (QMB)

ARTICLE 1. DEFINITIONS

Section
R9-29-101. ~~Definitions~~ Location of Definitions

ARTICLE 5. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

Sections
~~R9-29-501.~~ ~~General Provisions for All Grievances and Appeals~~ Repealed
R9-29-501. General Provisions for a Grievance and a Request for Hearing
~~R9-29-502.~~ ~~Eligibility Appeals and Hearing Requests for Applicants or Recipients of QMB Services~~ Repealed
R9-29-502. Grievance
~~R9-29-503.~~ ~~Grievances~~ Repealed
R9-29-503. Eligibility Hearing for an Applicant or a Member Under 9 A.A.C. 29, Article 2

ARTICLE 1. DEFINITIONS

R9-29-101. ~~Definitions~~ Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 29 are found in the following:

Definition	Section or Citation
"1st-party liability"	R9-22-110
"3rd-party"	R9-22-110
"3rd-party liability"	R9-22-110
"AHCCCS"	R9-22-101
"ALTCS"	A.R.S. § 36-2932
"CFR"	R9-29-101
"Contractor"	R9-22-101
"Director"	R9-22-101
"Dual eligible"	A.R.S. § 36-2971
"Enrollment"	R9-22-117
"Grievance"	R9-22-108
"Hearing"	R9-22-108
"Program contractor"	A.R.S. § 36-2971
"QMB-only"	R9-29-101

B. General definitions. The following words and phrases, in addition to definitions contained in A.R.S. § 36-2971, have the following meanings unless the context of the Chapter explicitly requires another meaning:

~~1.~~ "1st-party liability" ~~has the meaning~~ is defined in 9 A.A.C. 22, Article 1.
~~2.~~ ~~"3rd party" has the meaning~~ "3rd-party" is defined in 9 A.A.C. 22, Article 1.
~~3.~~ "3rd-party liability" ~~has the meaning~~ is defined in 9 A.A.C. 22, Article 1.
~~4.~~ "AHCCCS" ~~has the meaning~~ is defined in 9 A.A.C. 22, Article 1.
~~5.~~ "ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2931 et seq.
~~6.~~ "CFR" means the Code of Federal Regulations.
~~7.~~ "Contractor" ~~has the meaning~~ is defined in 9 A.A.C. 22, Article 1.
"Director" is defined in 9 A.A.C. 22, Article 1.
~~8.~~ "Dual eligible" ~~has the meaning~~ is defined in A.R.S. § 36-2971.
~~9.~~ "Enrollment" ~~has the meaning~~ is defined in 9 A.A.C. 22, Article 1.
"Grievance" is defined in 9 A.A.C. 22, Article 1.
"Hearing" is defined in 9 A.A.C. 22, Article 1.
~~10.~~ "Program contractor" ~~has the meaning~~ is defined in A.R.S. § 36-2971.
~~11.~~ "QMB-only" means Qualified Medicare Beneficiary only and is defined in A.R.S. § 36-2971.

ARTICLE 5. GRIEVANCE AND ~~APPEAL PROCESS~~ REQUEST FOR HEARING

~~R9-29-501. General Provisions for All Grievances and Appeals~~ Repealed

~~All grievances and appeals regarding QMB shall be filed and processed as specified in A.A.C. R9-22-801.~~

R9-29-501. General Provisions for a Grievance and a Request for Hearing

A grievance and a request for hearing under this Chapter shall comply with R9-22-801.

~~R9-29-502. Eligibility Appeals and Hearing Requests for Applicants or Recipients of QMB Services~~ Repealed

~~A. An individual affected by an adverse eligibility action may appeal and request a hearing concerning any of the following adverse eligibility actions:~~
~~1. Denial of eligibility;~~
~~2. Discontinuance of eligibility; or~~
~~3. Delay in the eligibility determination.~~

~~B. Notice of an adverse eligibility action shall be personally delivered or mailed to the affected individual by regular mail. For purposes of this Section, the date of the Notice of Action shall be the date of personal delivery to the individual or the postmark date, if mailed.~~

~~C. Appeals and requests for hearing.~~
~~1. An applicant, eligible person, or authorized representative may appeal and request a hearing from an adverse eligibility action by completing and submitting, no later than 35 days after the date of the Notice of Action, the AHCCCS request for hearing form, or a written request that contains the following information:~~
~~a. The case name;~~
~~b. The adverse eligibility action being appealed; and~~
~~c. The reason for appeal.~~

   ~~2. The request for hearing shall be submitted to the Office of Grievance and Appeals, AHCCCS Administration. If the request for hearing is submitted by mail, the date of request shall be the postmark date. If the request for hearing is submitted in person, the date of the request shall be the date on which the request is submitted to the Office of Grievance and Appeals.~~

~~D. Eligibility office responsibilities.~~
   ~~1. If requested, the eligibility office shall assist the individual or authorized representative to complete the request for hearing.~~
   ~~2. The eligibility office shall send to the AHCCCS Office of Grievance and Appeals the Pre-Hearing Summary and documents pertinent to the denial or discontinuance action within 5 days after the date of receipt of a request for materials from the AHCCCS Office of Grievance and Appeals.~~
   ~~3. The eligibility office shall complete and send to the AHCCCS Office of Grievance and Appeals with the Pre-Hearing Summary a summary of the factual basis for the adverse eligibility action.~~

~~E. Eligibility and benefits during the appeal process.~~
   ~~1. Individuals appealing a discontinuance. A discontinuance is a termination of eligibility and benefits. An individual requesting a hearing within the time-frame specified in subsection (C) shall continue to be eligible and receive benefits until an adverse decision on appeal is rendered.~~
   ~~2. Individuals appealing a denial of eligibility.~~
      ~~a. A denial is an adverse eligibility decision that finds an applicant ineligible as a Qualified Medicare Beneficiary.~~
      ~~b. The effective date of a denial is the date of notice of an adverse action. An individual may appeal this denial within the time-frame specified in subsection (C). If the denial is overturned, the effective date of eligibility shall be established by the Director in accordance with federal and state law.~~

R9-29-502. Grievance
A grievance and request for hearing under this Chapter shall comply with R9-22-802.

~~R9-29-503. Grievances~~ Repealed
~~All grievances regarding QMB shall be filed and processed as specified in A.A.C. R9-22-804.~~

R9-29-503. Eligibility Hearing for an Applicant or a Member Under 9 A.A.C. 29, Article 2
An eligibility hearing for a member or an applicant under this Chapter shall comply with R9-22-803.

NOTICE OF FINAL RULEMAKING

TITLE 12. NATURAL RESOURCES

CHAPTER 5. LAND DEPARTMENT

PREAMBLE

1. Sections Affected | **Rulemaking Action**

Sections Affected	Rulemaking Action
R12-5-701	Repeal

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. § 37-132(A)(1);

Implementing statutes: Laws 1997, Ch. 249, §§ 8, effective July 21, 1997, repealed A.R.S § 37-281.04 which had authorized the Arizona State Land Department to lease State lands suitable for recreational purposes to the state, counties, cities and towns for a lease term not to exceed 25 years for use for recreational purposes.

3. The interim effective date of the summary rules:

February 4, 2000

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

Name: Richard B. Oxford, Director
Operations Division

Address: Arizona State Land Department
1616 West Adams
Phoenix, Arizona 85007

Telephone: (602) 542-4602

Fax: (602) 542-5223

5. The concise explanatory statement, including an explanation of the rule and the agency's reasons for initiating it:

A.R.S. § 41-1027(A)(1) authorizes use of the summary rulemaking when an agency's rules become obsolete by repeal of the agency's statutory authority. The Department's authority to lease state land for recreational purposes to state parks, counties, cities or towns a lease term not to exceed 25 years was repealed in 1997 (Laws 1997, Ch. 249, § 8, effective July 21, 1997). The former statute [A.R.S. §§ 37-281.04(B)] required the applicant to submit an application and a plan for a recreational lease. Rule R12-5-701 addressed the required components of the plan and the procedure for processing the application.

6. 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

7. The economic, small business, and consumer impact:

An economic, small business and consumer impact statement is not required under A.R.S. § 41-1055 (D) (2).

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

Not applicable

9. 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: Not applicable

Time: Not applicable

Location: Not applicable

Nature: No oral proceedings or hearings were scheduled nor requested.

Name: Richard B. Oxford, Director
Operations Division

Address: Arizona State Land Department
1616 West Adams
Phoenix, Arizona 85007

Telephone: (602) 542-4602

Fax: (602) 542-5223

10. An explanation of why summary proceedings are justified.

A.R.S. § 41-1027(A)(1) authorizes use of the summary rulemaking process when an agency's rules become obsolete by repeal of the agency's statutory authority. The Department's authority to lease state land for recreational purposes to state parks, counties, cities or towns for 25 years was repealed in 1997 (Laws 1997, Ch. 249, § 8, effective July 21, 1997).

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

None

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

None

13. The full text of the rules follows:

TITLE 12. NATURAL RESOURCES

CHAPTER 5. LAND DEPARTMENT

ARTICLE 7. SPECIAL LEASING PROVISIONS

Section
R12-5-701. ~~Lease of Trust Lands to the Arizona State Parks Board, Counties and Cities or Towns for Recreation Purposes~~ Repealed

ARTICLE 7. SPECIAL LEASING PROVISIONS

R12-5-701. ~~Lease of Trust Lands to the Arizona State Parks Board, Counties and Cities or Towns for Recreation Purposes~~ Repealed

~~**A.** The plan required pursuant to A.R.S. § 37-281.04 shall consist of the following:~~

1. ~~Site location study: A preliminary location analysis for site selection including general inventory information and comparative analyses of alternative sites.~~
2. ~~Conceptual master plan: A master plan for the proposed leased lands depicting circulation patterns and the types and locations of all proposed facilities. The master plan must contain a plan narrative that addresses the phasing of development, operation and maintenance plans for the duration of the lease and the funding sources for the proposed development. The plan and its components must be professionally prepared.~~

~~B. Application procedure:~~

1. ~~The site location study portion of the plan shall accompany the application along with the $20.00 filing fee.~~
2. ~~The State Land Commissioner will determine if recreational use is the highest and best use of the site based upon the data provided by the applicant and other information available to the State Land Department.~~
3. ~~If the site location study portion of the plan is approved, the conceptual master plan must be submitted to the Department within 30 days of the date of approval.~~
4. ~~Issuance of the lease and the nature of the lease terms are dependent upon the Commissioner's approval of the conceptual master plan and his determination that such a lease is in the best interests of the trust.~~

~~C. Land use:~~

1. ~~Development and use of the leased lands must be consistent with the conceptual master plan and the phased development schedule. Any substantial deviation requires the prior written approval of the Commissioner.~~
2. ~~Any use of land other than for recreational purposes will subject the lease to cancellation by the Commissioner.~~
3. ~~The Commissioner has the discretion to lease the land for other uses compatible with and in addition to the specified recreational uses.~~

Editor's note: In accordance with A.A.C. R1-1-109(D), the following Notice of Final Rulemaking is republished to correct printing errors in the text and replaces Notice of Final Rulemaking: 6 A.A.R. 3091-3093, August 18, 2000.

NOTICE OF FINAL RULEMAKING

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Sections Affected	Rulemaking Action
Article 15	Amend
R15-5-1502	Amend
R15-5-1506	Amend
R15-5-1507	Amend
R15-5-1512	Amend
R15-5-1513	Repeal

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. §§ 42-1005 and 42-5003

Implementing statute: A.R.S. § 42-5071

3. The effective date of the rules:

July 18, 2000

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

Notice of Rulemaking Docket Opening: 5 A.A.R. 3235, September 17, 1999

Notice of Proposed Rulemaking: 6 A.A.R. 949, March 10, 2000

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

Name: Ernest Powell, Supervisor

Address: Tax Research & Analysis Section
Arizona Department of Revenue
1600 West Monroe
Phoenix, Arizona 85007

Telephone: (602) 542-4672

Fax: (602) 542-4680

E-Mail: azdor-tra@inetmail.att.net

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

These rules provide guidance regarding the application of transaction privilege tax to persons engaged in the business of leasing tangible personal property. As a result of legislative changes and the 5-year review of *Arizona Administrative Code* ("A.A.C.") Title 15, Chapter 5, the Department is proposing to amend or repeal these rules because the rules are obsolete, repetitive, or contrary to current statute. The Department also proposes to amend these rules to conform with current rulemaking guidelines.

7. Reference to any study that the agency relied on and its evaluation of or justification for the final 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

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

Not applicable

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

It is expected that the benefits of the rules will be greater than the costs. The repeal of R15-5-1513 will benefit the public by eliminating an obsolete rule that no longer serves its intended purpose. The amendment of R15-5-1502, R15-5-1506, R15-5-1507, and R15-5-1512 will benefit the public by providing additional guidance regarding the application of transaction privilege tax under the personal property rental classification. In addition, these proposed amendments will benefit the public by providing clearer and more concise information regarding the taxability of certain lease activities under the personal property rental classification. The Department will incur the costs associated with the rulemaking process. Taxpayers are not expected to incur any expense in the amendment of these rules.

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

Based on the review performed by the staff of the Governor's Regulatory Review Council, the Department made various nonsubstantive grammatical changes.

11. A summary of the principal comments and the agency response to them:

The Department did not receive any written or verbal comments on the rule action after the publication of the rulemaking in the Notice of Proposed Rulemaking.

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

None

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

None

14. Was the rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

ARTICLE 15. ~~SALES TAX – RENTAL OF~~ PERSONAL PROPERTY RENTAL CLASSIFICATION

Sections

R15-5-1502. General
R15-5-1506. Rental of Tangible Personal Property ~~property~~ to Government ~~government~~ Agencies ~~agencies~~
R15-5-1507. Rental of Tangible Personal Property ~~property~~ to Schools ~~schools~~, Churches ~~churches~~, and Other ~~other~~ Nonprofit ~~nonprofit~~ Organizations ~~organizations~~
R15-5-1512. Lease – Purchase ~~purchase~~ Agreements ~~agreements~~
R15-5-1513. ~~Data processing equipment~~ Repealed

ARTICLE 15. ~~SALES TAX – RENTAL OF~~ PERSONAL PROPERTY RENTAL CLASSIFICATION

R15-5-1502. General

A. Gross income derived from the rental of tangible personal property is included in ~~subject to~~ the tax base under the personal property rental ~~this~~ classification unless a specific statutory exemption, exclusion, or deduction applies. Examples of tangible personal property include: televisions, cars, ~~and~~ trucks, lawnmowers, floor polishers, tuxedos, uniforms, furniture, towels, and linens.

B. In this Article ~~For purposes of this rule~~, the terms "lease," "rental,"~~, "renting",~~ and ~~or~~ "leasing" are used synonymously.

C. Gross income from the lease of tangible personal property to a lessee who subleases the property is not taxable under the personal property rental classification if the lessee is engaged in the business of leasing the property under the personal property rental classification. ~~Income from the subleasing of personal property, or any portion thereof, is taxable under this classification. No deduction is allowed for rental payments made to another lessor.~~

D. Gross ~~The gross~~ income from the rental of tangible personal property includes charges ~~made~~ for installation, labor, insurance, maintenance, ~~and~~ repairs, pick-up, delivery, assembly, set-up, ~~title and license fees~~, personal property taxes, and penalty fees ~~lieu taxes~~ even if ~~though~~ these ~~such~~ charges are ~~may be~~ billed as separate items, unless a specific statutory exemption, exclusion, or deduction applies.

~~**E.** When an automobile, truck or other vehicle, required to be registered and licensed by the laws of this state, is rented or leased for a period exceeding 1 year and the lessee pays the cost of license renewal, the amount so paid shall be included in the gross rental income of the lessor.~~

R15-5-1506. Rental of Tangible Personal Property ~~property~~ to Government ~~government~~ Agencies ~~agencies~~

A lessor's gross income ~~Income~~ from the rental of tangible personal property to the United States Government, the State ~~state~~ of Arizona, or ~~and all~~ other governmental subdivisions~~,~~ is taxable ~~subject to the tax~~ under the personal property rental classification unless a specific statutory exemption, exclusion, or deduction applies.

R15-5-1507. Rental of Tangible Personal Property ~~property~~ to Schools ~~schools~~, Churches ~~churches~~, and Other ~~other~~ Nonprofit ~~nonprofit~~ Organizations ~~organizations~~

A lessor's gross income ~~Income~~ from the rental of tangible personal property to a school, church, or ~~schools, churches, and~~ other nonprofit organization ~~organizations~~ is taxable under the personal property rental classification unless a specific statutory exemption, exclusion, or deduction applies.

R15-5-1512. Lease – Purchase ~~purchase~~ Agreements ~~agreements~~

A. A lessor's gross income ~~Income~~ from the leasing of tangible personal property that includes ~~with~~ an option to purchase the tangible personal property ~~article~~ is taxable under the personal property rental ~~this~~ classification until the lessee exercises ~~such time as~~ the purchase option ~~to purchase is exercised~~.

B. Gross income ~~Payments~~ received after the lessee exercises the purchase option ~~has been exercised~~ is ~~are~~ taxable under the retail classification ~~(see Article 18)~~.

R15-5-1513. ~~Data processing equipment~~ Repealed

~~**A.** Income from the leasing or renting of data processing equipment (hardware) and any other item of tangible personal property located within this state is taxable under this classification.~~

~~**B.** Income from services rendered in whole or in part in connection with the use of such hardware is exempt, including income from the multiple use of hardware wherein no single customer has exclusive use of the equipment for a fixed period of time, or where the customer does not exclusively control all manual operations necessary to operate the equipment, or both.~~

~~**C.** Income from professional and technological services such as classroom education, systems support engineering services and computer programs (software), is tax exempt.~~

~~D.~~ ~~When rental income is received together with income from exempt services, the charges for each shall be separately stated on billings and invoices or otherwise clearly reflected in the books and records of the taxpayer. If not so separately stated, the gross income from such transaction is taxable.~~

~~E.~~ ~~Income from transactions involving services rendered and including tangible property as inconsequential elements thereof is exempt.~~

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 4. BANKING DEPARTMENT

PREAMBLE

1. Sections Affected / **Rulemaking Action**

Sections Affected	Rulemaking Action
R20-4-502	Repeal
R20-4-506	Repeal
R20-4-520	Repeal
R20-4-521	Repeal
R20-4-532	Repeal
R20-4-536	Repeal

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. § 6-123 (2)

Implementing statutes: A.R.S. §§ 6-607, 6-634, and 6-636

3. The effective date of the rules:

August 3, 2000

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

Notice of Rulemaking Docket Opening, 6 A.A.R. 925, March 3, 2000

Notice of Proposed Rulemaking, 6 A.A.R. 1564, April 28, 2000

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

Name: John P. Hudock

Address: 2910 North 44th Street, Suite 310
Phoenix, Arizona 85018

Telephone: 602-255-4421, Ext. 167

Fax: 602-381-1225

E-mail: jhudock@azbanking.com

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

These rules regulate the operation of Small Loan Companies. The Department proposes to repeal each of the listed Sections. The substance of each Section affected by this proposed rulemaking is now contained in a set of statutory revisions added to Arizona Revised Statutes, effective October 1, 1997, by Laws 1997, Ch. 248, § 2. Those revisions are codified at A.R.S. §§ 6-631 through 6-638.

R20-4-502 controls the scheduling of the first payment on a precomputed loan. That material is now contained in A.R.S. § 6-634 (A).

R20-4-506 controls the computation of a net unpaid loan balance. That material is now contained in A.R.S. § 6-634 (B).

R20-4-520 requires a licensee to keep a record of any refund or credit given. That material is now contained in A.R.S. § 6-607 (A) and 6-634 (B).

R20-4-521 requires a licensee to note charges on ledger cards. That material is now contained in A.R.S. § 6-607 (A) and 6-634 (B) & (C).

R20-4-532 requires a licensee to notify the Superintendent when the licensee discontinues operation. That material is now contained in A.R.S. § 6-603 (G).

R20-4-536 regulates minimum charges for insurance on property securing a small loan. That material is now contained in A.R.S. § 6-636.

7. 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:

The Department does not propose to rely on any study as an evaluator or justification for the proposed rule.

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

Not applicable

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

This proceeding is exempt from the requirement of an economic, small business, and consumer impact analysis under the provisions of A.R.S. § 41-1055(D)(3). The Department will submit an abbreviated economic, small business, and consumer impact statement reiterating the claim of exemption as required by A.R.S. § 41-1055 (E).

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

The Council's staff has not recommended editorial or stylistic changes to the originally proposed text of the rule. Staff's suggestion to revise the list of authorizing statutes was well made and has been implemented. There have been no substantive changes in the text of the rule.

11. A summary of the principal comments and the agency response to them:

The public was invited to comment in the Notice of Proposed Rulemaking. That invitation contained an agency contact name, address, telephone number, and fax number. However, only one comment was received. No arguments against adoption have been raised.

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

Not applicable

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

None

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

No

15. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING AND INSURANCE

CHAPTER 4. BANKING DEPARTMENT

ARTICLE 5. SMALL LOANS

Sections

R20-4-502. ~~First Installment on Precomputed Loans~~ Repealed
R20-4-506. ~~Computation of Net Unpaid Loan Balance~~ Repealed
R20-4-520. ~~Record of Refund or Credit Given~~ Repealed
R20-4-521. ~~Noting Charges on Ledger Card~~ Repealed
R20-4-532. ~~Report to Superintendent Upon Discontinuance of Operations~~ Repealed
R20-4-536. ~~Minimum Insurance Premium Charge~~ Repealed

ARTICLE 5. SMALL LOANS

R20-4-502. ~~First Installment on Precomputed Loans -- A.R.S. § 6-626~~ Repealed

~~The first installment, on precomputed loans, shall be computed in like manner except that if it is adjusted for more or less than one calendar month from the date of the loan, such adjustment shall be on the basis of 1/30th of the precomputed charges for a month for each day involved in such adjustment.~~

R20-4-506. ~~Computation of Net Unpaid Loan Balance -- A.R.S. § 6-626~~ Repealed

~~On any precomputed loan prepaid in full by cash or on which a request is made for the net amount thereof for the purpose of making such prepayment, whether by the borrower or any other person authorized by the borrower to make such request and payment, the refund due the borrower as of the date of tendering prepayment shall be deducted from the unpaid balance of the loan and the licensee may receive only the net unpaid balance of the loan.~~

R20-4-520. Record of Refund or Credit Given -- A.R.S. §§ 6-616, 6-621 Repealed

Licensee shall maintain as part of his records evidence of every refund or credit given the borrower for every loan renewed or prepaid.

R20-4-521. Noting Charges on Ledger Card -- A.R.S. §§ 6-616, 6-621 Repealed

A notation of all default or extension charges must appear on the face of the borrower's ledger card.

R20-4-532. Report to Superintendent Upon Discontinuance of Operations -- A.R.S. § 6-611 Repealed

Upon discontinuance of operations, each licensee shall immediately notify the Superintendent of Banks of such action, and file within 30 days, a report of the activities for the period in which he operated. Sale of assets or outstanding accounts by a licensee shall constitute discontinuance of operations, and the licensee and the purchasing licensee or applicant shall notify the Banking Department fully of such change of operations and file all necessary applications and reports within 30 days of such sale.

R20-4-536. Minimum Insurance Premium Charge -- A.R.S. § 6-632 Repealed

If a licensee sells insurance on property securing a loan through an insurance policy or policies which provide for a minimum premium charge:

1. The licensee must extend coverage to the borrower for the full term and amount of insurance to which the minimum charge entitles the borrower regardless of whether the amount of the loan or the lender's loss payable is for a lesser amount or the term of the loan or the lender's loss payable term is for a lesser time.
2. The licensee shall not sell insurance in such a manner as to impose on the borrower avoidable minimum premium charges, as, for example, the selling of two or more minimum premium policies to provide coverage which might have been provided in a single policy. Any such avoidable minimum premium charges shall be considered additional charges under the loan. (Section 6-632, Title 6, Chapter 5, A.R.S.)