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 or the Attorney General. 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 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

[R05-413]

PREAMBLE

1. Sections Affected	Rulemaking Action
R20-6-1901	Amend
R20-6-1902	Amend
R20-6-1903	Amend
R20-6-1904	Repeal
R20-6-1904	Renumber
R20-6-1904	Amend
R20-6-1905	Repeal
R20-6-1905	Renumber
R20-6-1905	Amend
R20-6-1906	Renumber
R20-6-1906	Amend
R20-6-1907	Renumber
R20-6-1907	Amend
R20-6-1908	Renumber
R20-6-1908	Amend
R20-6-1909	Renumber
R20-6-1909	New Section
R20-6-1910	Repeal
R20-6-1910	New Section
R20-6-1911	Renumber
R20-6-1911	New Section
R20-6-1912	New Section
R20-6-1913	New Section
R20-6-1914	New Section
R20-6-1915	New Section
R20-6-1916	New Section
R20-6-1917	New Section
R20-6-1918	New Section
R20-6-1919	New Section
R20-6-1920	New Section
R20-6-1921	New Section

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

Authorizing statutes: A.R.S. §§ 20-143, 20-1051(5), 20-1054(A)(2), 20-1078

Implementing statutes: A.R.S. §§ 20-143, 20-1051(5), 20-1054(A)(2), 20-1078

3. The effective date of the rules:

December 31, 2005

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 2946, July 23, 2004

Notice of Proposed Rulemaking: 11 A.A.R. 1474, April 22, 2005

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

Name: Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th St., Second Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

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

A.R.S. § 20-1054 (A)(2) provides for issuance of a certificate of authority to an HCSO if the director is satisfied that "The health care services organization [shall constitute] an appropriate mechanism to achieve an effective health care plan pursuant to this title and any rule that is adopted by the director." An adequate network is one component of an appropriate mechanism to achieve an effective health care plan. The Department proposes rules to establish the standards that HCSOs must meet in order for the Director to determine that an HCSO has an adequate network.

Under Laws 2000, Chapter 355, effective July 1, 2001, regulatory authority over health care services organizations (HCSOs), previously bifurcated between the Arizona Department of Health Services (DHS) and the Arizona Department of Insurance (ADOI), became consolidated under ADOI. The consolidated regulatory structure brought new responsibilities to ADOI, including new rulemaking responsibilities and authority to file temporary exempt rules. The HCSO rules in effect at the time, AAC §§ R9-12-101 to R9-12-116, had been promulgated by DHS in 1973 and never amended.

Effective July 1, 2001, the Department adopted temporary exempt rules. The text of these rules was very similar to the text of rules originally promulgated by DHS in A.A.C. R9-12-101 through R9-12-116. The purpose of the temporary rules was to assure the Department had the authority to enforce the extant regulatory standards while proceeding with the complex task of the first revision in 30 years. The Department made technical changes in the temporary rules to substitute references to the Department for references to DHS and comply with current rulewriting standards. The Department also modified the rules as needed to reflect changes in certain statutory requirements or definitions.

In 2001, the Department convened a rulemaking advisory group made up of stakeholders including consumers, HCSOs, and providers from around the state of Arizona. The Department has held more than 20 meetings, including several teleconferences, in Phoenix, Tucson and Prescott to discuss informal drafts of the rulemaking. The Department has provided numerous opportunities to the stakeholder groups for comment on informal drafts, has distributed meeting minutes and comparison drafts between meetings and has made many revisions to the draft rules in response to stakeholder input. The stakeholder participation has been crucial to the Department in understanding and addressing network adequacy issues. The proposed rules are the result of the iterative process between the Department and stakeholders

The Department has addressed only the issue of network adequacy in this rulemaking. There are other important factors that go into deciding whether an HCSO constitutes an appropriate mechanism to achieve an effective health care plan. Early on, however, stakeholders helped the Department to define and prioritize rulemaking topics, with network adequacy at the top of the list. Stakeholders and the Department agreed that quality assurance and other issues were very important but less pressing than network adequacy. A.A.C. R20-6-1911 in the current rule (Section A.A.C. R20-6-1908 in the proposed rule) specifically addresses quality assurance. In deference to the priorities established with the stakeholder group, the Department has made technical and grammatical to make the rule more clear, concise and understandable, but not substantive changes to proposed R20-6-1908. The Department will address the substance of quality assurance and other topics in a future rulemaking with stakeholder input on those issues.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

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 consumers impacted by this rulemaking are HCSO members (members), employers that obtain health care coverage from HCSOs (employers), and health care providers. The new network adequacy provisions of these rules will provide protections to members and employers and improve member access to health care services. The updated, realistic network adequacy standards and standardized HCSO communications and processes will benefit and provide protections for health care providers and the members they serve.

The Department does not anticipate any direct increase in costs for members or health care providers as a result of these rules. The rules are minimal standards and should cause little disruption to current HCSO operations. The Depart-

ment does not anticipate increased costs to HCSOs, but if there are increased costs, they should be minimal. It is possible that HCSOs could pass along those minimal increased costs to employers and enrollees.

Two kinds of small businesses may be indirectly impacted by this rule. First, many physicians or other health care practitioners with small private practices are small businesses. The impact on those small businesses will be essentially the same as the impact on the health care provider as a consumer.

Second, some small businesses purchase health care coverage for their employees from HCSOs. To the extent these rules may increase costs somewhat for HCSOs, the HCSOs may also increase premiums for the small businesses. The impact on the small business employers will be the same as the impact on HCSO enrollees in general.

The Department is not aware of small businesses that will be directly impacted by this rule, therefore, the Department does not believe it is necessary to reduce the impact on small businesses.

There will be a minimal economic impact on the Department, the Secretary of State and the Governor's Regulatory Review Council for costs associated with the rulemaking process.

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

R20-6-1902 is revised to delete the definition for "licensed hospital emergency facility" in response to a comment for the staff of the Governor's Regulatory Review Council.

R20-6-1920(B) is revised as follows:

If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in-area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

R20-6-1921(4) is revised as follows:

Whether an enrollee has requested and obtained covered services from a contracted provider whose ~~locations~~ location, or appointment availability, or capacity result in the HCSO's non-compliance; and

Additional non-substantive changes made to correct typographical errors and to make the rules more clear, concise, and understandable and in response to comments from the Governor's Regulatory Review Council.

11. A summary of the comments made regarding the rule and the agency response to them:

The Department held four oral proceedings on this rulemaking. The Department received no comments for the record at the oral proceedings held in Tucson and Flagstaff. The Department did receive comments at the two oral proceedings in Phoenix, a follow-up comment letter and three e-mail comments.

1. Comment: A commenter stated that the stakeholder process used for this rulemaking was fair and open and that comments made by his organization were taken seriously and appropriate changes were made in response to the comments. He stated that his organization is in 100% agreement with the way the rules have been written and feels that the rules represent a good balance between all the stakeholders.
   Response: The Department appreciates the comments and the participation and input of all the stakeholders who participated in the rule drafting process.
2. Comment: Under R20-6-1920(B) Travel Requirements, HCSOs would be required to reimburse enrollee travel expenses for medical services outside the service area. There are occasions where an HCSO has prior-authorized a medical service that is available in-area but the enrollee prefers to receive that service out of the service area. In those cases where the enrollee chooses to travel out-of-area to receive an available medical service, the HCSO should not have to reimburse the enrollee for any travel expenses. The medical service would be covered, but the travel expenses should not be paid by the HCSO if the only reason the enrollee is going out of area is convenience.
   To clarify that travel expenses are not reimbursable when the service is available in-area, I would suggest adding the following phrase into R20-6-1921(B); Except as provided under R20-6-1904(E), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services THAT ARE AVAILABLE in-area.
   Response: The Department agrees that clarification of this point is appropriate and has revised R20-6-1920(B) as follows:
   > If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in-area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.
3. Comment: While this has been a long rulemaking, the finished product reflects the hard work that the Department and the stakeholders have put into it.
   Response: The Department appreciates the comments and the input of all the stakeholders who participated in the

rule-drafting process.

4. Comment: A chiropractor, optometrist, or podiatrist is not a physician. They can accurately be called providers, but to call them physicians is misleading to people who do not know the difference and could be taken advantage of.
   Response: The Department's stakeholder group addressed the definition of physician early in the rule-development process. The Department believes that the definition is not misleading. It applies only to these rules and is consistent with various statutory references to chiropractors and podiatrists as physicians. See, e.g., A.R.S. §§ 20-1057.03(F)(6) (chiropractors), and 32-801(9) (podiatrists). The proposed rule allows an HCSO to meet the network adequacy standards by using either a "physician" or a non-physician "practitioner" to provide services, as long as each is acting within the scope of practice and can and meet the medical needs of the HCSO enrollee. The rule does not require, and should not result in, any type of physician or practitioner acting outside the scope of practice. As a result, it does not mislead consumers.
5. Comment: R20-6-1912(A)(4): In the first line, the citation to the other subsections needs to be changed. It references subsection R20-6-1916(A(2)(a) and should reference R20-6-1912(A)(3)(a). In the second line, the reference should be to R20-6-1912 (A)(3)(e). Page 21, subsection R20-6-1921(4): It appears the word "provider" or "providers" is missing between the words "contracted" and "whose."
   Response: The Department appreciates the corrections and has made the appropriate changes.
6. Comment: The commenter acknowledges the revisions ADOI has made to the rules in the proposed form to address the commenter's previously articulated concerns and ADOI's clarification that although the rules do not apply to emergency services as defined in the emergency services statute, they **will** apply to emergency care for admitted inpatients. (Emphasis in the original). ADOI's revisions address one of the most important concerns of Arizona hospitals. Hospital staff frequently have significant difficulty finding on-call coverage for a particular specialty. By clarifying the requirement that HCSOs have a sufficient network to provide admitted inpatients with "timely coverage" from a contracted provider in such situations, the rules will help further align the incentives of hospitals, HCSOs, and ADOI in emergency situations. The commenter supports these rules as proposed with the revisions ADOI has made.
   Response: The Department appreciates the comment.
7. Comment: The commenter stated that it trusts the Department will accept and act on emergency on-call concerns as expressed not only by patients or enrollees but also by the hospital staff who face the continued problem of locating on-call network physicians to take care of admitted inpatients in the middle of the night.
   Response: The Department intends to fulfill its statutory and regulatory obligations to enforce these rules.
8. Comment: The commenter encourages the Department to take this unique opportunity to help solve the large and difficult problem of availability of on-call physicians in the emergency department. By not applying the rules to emergency services provided in hospital emergency departments, ADOI leaves in place a patchwork quilt where certain rules apply in certain situations and slightly different rules apply in different situations. ADOI should take this opportunity to state that as part of creating an adequate network of care, HCSOs must require their contracted professionals to treat patients needing emergency care in hospital departments.
   Response: This commenter is addressing a very serious problem in the Arizona health care community, i.e., that many physicians in key specialties no longer take emergency department call. This results, not infrequently, in situations where there simply is no specialist available or willing to come to the emergency department to treat patients. The Department believes that there are complicated reimbursement, social and "lifestyle" reasons for this trend, all of which are outside the scope of these network adequacy rules.
   The Department has determined that the network adequacy rules should not apply to emergency services in hospital emergency departments because an HCSO cannot control where an enrollee receives those services and cannot require an enrollee to obtain those services in-network as a condition of coverage. Coverage for emergency services in hospital emergency departments is required not only under the HCSO statute and rules but also under Arizona's Emergency Services Access law. A.R.S. § 20-2803. When network status of the facility or the health care professionals is completely irrelevant to the HCSO's obligation to pay for the services, it would serve no useful purpose to require an HCSO to have a network contract with every emergency department and qualified professional in its service area.
9. Comment: Commenter noted that development of this rule package was a four-year arduous process that led to a package that is responsive to the needs of managed care as well as the needs of hospitals and other providers.
   Response: The Department appreciates the comments and the input of all the stakeholders who participated in the rule-drafting process.

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 made as an emergency rule?

No.

15. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

Section
R20-6-1901. Applicability
R20-6-1902. Definitions
R20-6-1903. Documentation
~~R20-6-1904. Service Agreements~~
~~R20-6-1905. Examination and Review~~
~~R20-6-1906~~R20-6-1904. Health Care Plan
~~R20-6-1907~~R20-6-1905. Geographic Area
~~R20-6-1908~~R20-6-1906. Chief Executive Officer
~~R20-6-1909~~R20-6-1907. Medical Director
~~R20-6-1910. Medical Records~~
~~R20-6-1911~~R20-6-1908. Quality Assurance
R20-6-1909. Evaluation of Network
R20-6-1910. Process for Referral, Prior Authorization, Pre-certification, or Network Exception
R20-6-1911. HCSO Communication with Providers
R20-6-1912. Network Directories
R20-6-1913. Demographic Information Reports
R20-6-1914. Access
R20-6-1915. Alternative Access
R20-6-1916. Availability Ratios
R20-6-1917. Geographic Availability in an Urban Area
R20-6-1918. Geographic Availability in a Suburban Area
R20-6-1919. Geographic Availability in a Rural Area
R20-6-1920. Travel Requirements
R20-6-1921. Enforcement Consideration

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

R20-6-1901. Applicability

A. ~~These rules apply~~ This Article applies to:
1. ~~all~~ All proposed and existing health care services organizations (HCSOs)~~.~~ , and
2. Each product offered by an HCSO under the HCSO's certificate of authority.

B. The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.

C. The Department shall not require an ~~An~~ existing HCSO ~~shall not be required~~ to re-file ~~all~~ information already on file with the Department, but ~~it~~ the HCSO shall modify its operations and procedures as may be necessary to comply with this Article and file with the Department all additional information necessary to make statements complete and current.

D. This Article applies to inpatient emergency care, but does not apply to emergency services.

E. This Article applies only to covered services.

R20-6-1902. Definitions

In this Article the following definitions apply:

"Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.

"Adult" means an enrollee in the age group the HCSO has designated for an adult.

"Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.

"Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical sup-

plies dispensed by order or prescription of a provider with the appropriate prescribing authority.

"Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.

"Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization ~~in accordance with~~ according to applicable legal requirements and policies approved by the governing authority.

"Child" means an enrollee in the age group the HCSO has designated for children.

"Contracted" means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.

"Covered" or "covered services" means the health care services described as covered benefits in the HCSO's evidence of coverage.

"Day" means calendar day unless specified otherwise.

"Department" means the Department of Insurance.

"Effective process" means written policies and procedures that:

Outline the steps that the HCSO implements and consistently follows internally,

The HCSO subjects to internal quality improvement, and

The HCSO communicates to providers when established or changed.

"Emergency services" has the meaning in A.R.S § 20-2801(3).

"Enrollee" means an individual who is enrolled in a health plan operated by an HCSO.

"Facility" means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.

"Governing authority" means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the ~~health care services organization~~ HCSO is vested.

"HCSO" means a health care services organization.

"Health care services" has the meaning in A.R.S. § 20-1051(6).

"High profile" means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.

"Hospital" means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.

"Inpatient care" means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.

"Inpatient emergency care" means covered services that would be emergency services if provided in a licensed hospital emergency facility.

"License" means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.

"Medically necessary" has the meaning set forth in the HCSO's evidence of coverage.

"Network" means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO's health benefit plan.

"Network exception" means an enrollee receives covered services from a non-contracted provider either:

Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or

For any reason the HCSO determines it is in the enrollee's best interests to receive care from a non-contracted provider.

"Non-contracted" means a provider that does not have a contract with an HCSO to provide services to an enrollee.

"Normal business hours" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.

"Outpatient care" means covered services that an enrollee who is not an inpatient receives.

"Pediatric primary care provider" means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.

"Physician" means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.

"Practitioner" means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.

"Preventive care" means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:

Immunizations,

Health education,

Health evaluation and follow-up,

Early disease detection,

Screening tests appropriate for a person's age and gender, and

Periodic health care examinations.

"Primary care" means ~~initial treatment or screening of enrollees~~ any specialty the HCSO designates as primary care.

~~"Primary care physician" means a general practitioner, family physician, internist or pediatrician.~~

"Primary care physician" or "PCP" means a physician or practitioner practicing in a specialty the HCSO designates as primary care.

"Provider" means any physician, practitioner, ancillary provider, or facility.

"Quality improvement" means an HCSO's system for assessing and improving the level of performance of key process and outcomes.

"Routine care" means covered primary care for an enrollee's non-urgent, symptomatic condition.

"Rural" means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

"Service area" means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).

"Specialty care provider" or "SCP" means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.

"Specialty" or "specialty care" means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician's or practitioner's license.

"Special hospital" means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.

"Suburban area" means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.

"Telemedicine" means diagnostic, consultation, and treatment services that occur in the physical presence of an enrollee on a real-time basis through interactive audio, video, or data communication.

"Timely" means services are provided at the time when medically necessary.

"Travel expenses" has the meaning set forth in writing by an HCSO.

"Urban area" means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.

"Urgent care" means unscheduled services for an enrollee's condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

R20-6-1903. Documentation

The ~~chief executive officer (CEO)~~ CEO shall ensure that the HCSO's policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

~~**R20-6-1904. Service Agreements**~~

~~The HCSO shall have a written service agreement with each primary care physician who provides services on a continuing basis, except for HCSO employees that specifies the terms and conditions for services provided to the HCSO.~~

~~**R20-6-1905. Examination and Review**~~

~~The Director may inspect an HCSO facility and the facility of any primary care physician with whom the HCSO contracts for services.~~

~~R20-6-1906~~R20-6-1904. Health Care Plan

A. ~~The applicant~~ An HCSO shall submit a statement to the Department that describes the proposed health care plan~~, facilities, and personnel~~.

B. The HCSO shall have an organized system for the delivery of health care services contained in subsection ~~(F)~~ (D) ~~of this Section~~ that includes the following:

1. ~~Physicians, registered nurses and other professional and technical personnel who~~ Contracted providers that provide services under the plan;
2. ~~Procedure that promotes~~ An effective process to promote a continuing relationship between an enrollee and the same ~~primary care physician~~ PCP; and
3. ~~A procedure for~~ An effective process for referrals that ensures continuity of care to ~~enrollees~~ an enrollee.

C. The HCSO shall list:

1. The proposed or actual enrollment;
2. The number and names of ~~physicians~~ contracted, employed, or HCSO-owned providers that will serve the enrollees and the board eligibility or certification of each physician, if ~~any~~ applicable; and
3. ~~The number and type of support staff that will serve enrollees; and~~
4. 3. The plan for providing ~~specialty medical~~ covered services to enrollees as required under this Article.

~~D.~~ ~~All care provided by the HCSO, whether provided by its own personnel or on a contract basis, shall be by a licensed:~~

1. ~~Practitioner of the healing arts;~~
2. ~~Health care institution; or~~
3. ~~Clinical laboratory.~~

~~E.~~ ~~The health care services described in subsections (E)(1), (2), (3), and (6) of this Section (E)(1) through (E)(3) and (E)(6) shall be provided seven days per week, and 24 hours per day.~~

~~F~~D. The HCSO's health care plan shall provide~~,~~ within the geographic area served~~, at least~~ the following basic health care services ~~that shall be~~ covered by the monthly charges ~~set forth~~ in the evidence of coverage:

1. Emergency care that includes emergency services and inpatient emergency care ~~defined in A.R.S. § 20-2801(3)~~;
2. Inpatient ~~general hospital~~ care;
3. ~~Physician care~~ Specialty care, primary care, or ancillary care that ~~includes necessary~~ includes diagnostic and therapeutic services ~~provided by a person who has a current, and valid Arizona license to practice medicine and surgery~~;
4. Outpatient care~~; that includes preventive, diagnostic, and therapeutic services, including primary care, furnished by, or under the direction of, a physician, laboratory, or radiology services. Primary care may include services provided by the following:~~
   a. ~~A physician's assistant who has a current and valid registration under the applicable provisions of A.R.S. Title 32, Chapters 13, 17 and 25, to provide patient services as specified in the job description or approved program; or~~
   b. ~~A registered nurse certified by the Arizona State Board of Nursing, to function in specialty areas under A.R.S. § 32-1601(B)(6).~~
5. ~~Health maintenance care designed to prevent illness and to improve the general health of enrollees, offered when medically necessary or indicated that shall include the following:~~
   a. ~~Immunizations;~~
   b. ~~Health education; and~~
   c. ~~Periodic health examinations, excluding certified health examinations for insurance qualification, school attendance, and employment. The periodic examinations shall include screening for vision and hearing and shall be offered when medically necessary or indicated, and on at least on the following schedule:~~
      i. ~~Enrollees aged 0 - 1 year -- 1 exam every 4 months~~
      ii. ~~2 - 5 years -- 1 exam every year~~
      iii. ~~6 - 40 years -- 1 exam every 5 years~~
      iv. ~~41 - 50 years -- 1 exam every 3 years~~
      v. ~~51 - 60 years -- 1 exam every 2 years~~
      vi. ~~61 years and over -- 1 exam every year~~
      vii. ~~A medical history and health examination offered to each new enrollee within 12 months after enrollment.~~
5. Preventive care; and
6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.

~~G~~E. The HCSO shall provide appropriate coverage for out-of-area emergency care to ~~enrollees when~~ an enrollee traveling outside the area served by the HCSO.

~~R20-6-1907~~R20-6-1905. Geographic Area

~~A.~~ ~~The applicant shall submit a statement that describes the geographic area in which it will provide services that are reasonably convenient to prospective enrollees.~~

1. ~~The applicant shall attach a map to the statement that describes the boundaries of the proposed geographic area and the location of each facility in which primary care will be provided under the plan; and~~

~~2. The applicant shall describe the proposed geographic area in at least one of the following ways:~~
~~a. Legal description;~~
~~b. Local governmental jurisdiction such as city or county;~~
~~c. Census tracts ;~~
~~d. Street boundaries; or~~
~~e. Area within a specified radius of a specified intersection, or a specified primary care center.~~

A. An applicant shall describe the proposed geographic area in at least one of the following ways:
1. Legal description,
2. Local governmental jurisdiction such as city or county,
3. Census tracts,
4. Street boundaries, or
5. Area within a specified radius of a specified intersection or a specified primary care center.

B. An applicant shall submit a map that shows the boundaries for the proposed geographic area.

C. An applicant shall submit a description of the proposed network including the data required under R20-6-1913(A)(2) and (A)(3).

~~B~~D. All advertising matter and sales material provided ~~to~~ a prospective ~~enrollees~~ enrollee shall include a description of the geographic area in terms readily understandable by the general public.

~~R20-6-1908~~R20-6-1906. Chief Executive Officer

A. The governing authority shall appoint a CEO who ~~shall have~~ has appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO ~~shall be~~ is the appointed representative of the governing authority and ~~shall be~~ is the executive officer of the HCSO.

B. The CEO shall have at least the following duties and responsibilities:
1. ~~Management of~~ Manage the HCSO;
2. Establish and implement policies, ~~and~~ procedures, and effective processes of the HCSO;
3. Act as liaison between the governing authority and the providers of healthcare and other services to the HCSO; and
4. Establish a written plan of authority that will be in place in the CEO's absence.

C. When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.

D. The HCSO shall ~~assure~~ ensure that all HCSO employees and ~~health practitioners covered by service agreements~~ contracted providers are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.

E. The HCSO shall designate a central place of business within the major geographic area served at which the CEO shall be based and from which the HCSO shall direct administrative activities.

~~R20-6-1909~~R20-6-1907. Medical Director

A. The HCSO shall designate a physician as medical director.

B. The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO~~,~~ if the medical director has appropriate education and experience to manage the HCSO.

C. The medical ~~director's~~ director responsibilities ~~shall~~ include:
1. ~~Supervision of~~ Supervising medical staff;
2. Performance planning and ~~evaluation of~~ evaluating medical staff;
3. ~~Coordination of activities of~~ Coordinating medical staff activities; and
4. ~~Development of~~ Developing medical care policies.

~~R20-6-1910. Medical Records~~

~~**A.** The HCSO shall maintain a medical record system that is capable of readily providing necessary information and assures continuity of enrollee care.~~

~~**B.** The HCSO shall maintain a centralized medical record in accordance with acceptable professional standards. The record shall include records that detail all symptoms presented, diagnoses made and medical treatment the HCSO provided to each enrollee during the term of enrollment. This requirement applies to all HCSO services provided to enrollees, whether provided by employees of the HCSO or non-employees at the request of the HCSO.~~

~~**C.** The HCSO shall designate a person to be generally responsible for administration of records.~~

~~**D.** The HCSO shall ensure that medical records are kept confidential and that only authorized personnel shall have access to the records.~~

~~**E.** Medical records shall not be removed from the premises where they are filed, except by subpoena, court order, or written permission or request of the patient who is the subject of the records. The HCSO may route the record, including X-ray film, to practitioners of the healing arts for consultation or evaluation.~~

~~**F.** Under A.R.S. § 20-1058(D) and A.R.S. § 20-1064, the HCSO shall make records available for review by the Director or~~

~~representatives of the Director. During routine surveys, the Department representatives shall review medical records of the HCSO on a random sample basis or upon complaint or special investigations, specific medical records may be reviewed.~~

~~**G.** The HCSO shall ensure that complete records are preserved for at least 10 years. If the enrollee is a minor, the record shall be maintained for at least two years after the enrollee has reached majority.~~

~~**H.** If an enrollee discontinues enrollment in the HCSO, the HCSO shall furnish, to the enrollee, upon written request, a written summary covering all pertinent phases of health care provided during enrollment. The summary shall include a copy of pertinent reports and results of diagnostic tests that might be used for comparative purposes, a record of immunizations and the last periodic health examination to another provider of health care services, as specified by the enrollee. This summary shall be furnished within 30 days after the enrollee requests disenrollment. The HCSO may charge a reasonable fee for the summary, based upon the cost of providing it.~~

~~R20-6-1911~~R20-6-1908. Quality Assurance

A. The HCSO shall provide an effective ~~method~~ process for a continuing review and evaluation of the ~~health care provided~~ covered services it provides to enrollees to ensure that:
1. ~~treatment~~ Treatment and level of ~~care were~~ covered services are appropriate and adequate~~,~~ and
2. ~~that the~~ The quality of ~~health care provided met acceptable standards , and that corrective action occurred or will occur, if indicated~~ covered services is acceptable to the HCSO.

B. The HCSO shall have a quality assurance committee that includes at least the ~~chief executive officer,~~ CEO or designee, the medical director, ~~practitioners of the healing arts, and allied health professionals~~ and representative network providers. ~~Services performed by practitioners of the healing arts shall be reviewed and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and dissemination of the reports.~~ The quality assurance committee shall:
1. Arrange for physicians or practitioners to review and evaluate covered services provided by others physicians or practitioners within the respective disciplines.
2. Adopt administrative procedures covering frequency of meetings, recordkeeping, committee reports, and disseminating the reports.

C. The ~~HCSO shall have a quality assurance that includes procedures to be used for each of~~ HCSO's effective process in subsection (A) shall include the following:
1. ~~Establishment of standards~~ Standards for health care;
2. Monitoring of care ~~provided~~;
3. Analysis of any ~~problems identified~~ deficiency;
4. ~~Correction of deficiencies including a~~ ~~time~~ Correcting a deficiency including submitting a schedule for ~~correction~~ correcting the deficiency, ~~and a link to a~~ requiring continuing education ~~program~~ for the provider, if appropriate~~;~~ , and
5. ~~Follow-up~~ follow-up and periodic reassessment of the ~~plan~~ deficiency.

R20-6-1909. Evaluation of Network

Each HCSO shall have an effective process to evaluate the adequacy of its network to provide an enrollee with timely covered services.

R20-6-1910. Process for Referral, Prior Authorization, Pre-certification, or Network Exception

A. An HCSO shall have an effective process for assisting an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.

B. An HCSO shall have an effective process during normal business hours for handling referrals, prior authorizations, pre-certifications, or network exceptions necessary for timely routine care. This process may include the HCSO's procedure for standing referrals required in A.R.S. § 20-1057.01.

C. Each HCSO shall have an effective process to handle referrals or network exceptions necessary for timely urgent care seven days a week.

D. An HCSO that requires prior authorization or precertification for urgent care shall have an effective process to handle requests for prior authorization or precertification 24 hours a day, seven days a week.

E. An HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

R20-6-1911. HCSO Communication with Providers

An HCSO shall have an effective process for communicating with contracted providers regarding the following:
1. The providers in the network,
2. Contractual or administrative changes relating to enrollee access or provider availability, and
3. Procedures for handling claims and grievances submitted by providers.

R20-6-1912. Network Directories

A. An HCSO shall publish a provider network directory as follows:

1. An HCSO shall list the name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners:
2. An HCSO may list ancillary providers by corporate or group name and is not required to list individual physicians or practitioners.
3. An HCSO is not required to list physicians or practitioners in the following areas of specialties or areas of practice:
   a. Emergency medicine;
   b. Anesthesiology, except anesthesiologists who provide pain management services;
   c. Hospital-based pathology;
   d. Hospital-based radiology; and
   e. Hospitalists.
4. An HCSO that lists any of the physicians or practitioners in subsections R20-6-1912(A)(3)(a) through (A) (3)(e) may list by corporate or group name and is not required to list individual physicians or practitioners.
5. An HCSO that uses hospitalists is not required to list the hospital affiliations of PCPs who do not admit or attend hospitalized members.
6. An HCSO shall publish a provider network directory that lists all its contracted facilities and contains:
   a. The name, address, and telephone number of each facility;
   b. For each hospital at which the HCSO uses hospitalists, if any, a statement that the HCSO uses hospitalists at that hospital;
   c. For an HCSO that uses hospitalists and does not list them in the directory, information on how an enrollee can find out what hospitalists or group of hospitalists it uses at each hospital;

C. The network directory shall conspicuously state in the directory the following:
1. Changes occur in the network after the directory is published and some providers listed in the directory may no longer be contracted,
2. Enrollee coverage may depend on the contract status of the provider,
3. Where the enrollee can obtain more recent directory information,
4. The effective date of the network directory, and
5. The method for an enrollee or prospective enrollee to find out which PCPs are accepting new enrollees from the HCSO.

D. Each HCSO shall make its network directory available on paper to enrollees or prospective enrollees requesting it. The HCSO shall:
1. Publish the paper directory at least once a year;
2. Update or supplement the information in the paper directory at least every six months;
3. Explain in the paper directory how an enrollee or prospective enrollee can use or get assistance using the HCSO's online or telephone directories, if any; and
4. Have discretion to list physicians' or practitioners' hospital affiliations in its paper directory.

E. Each HCSO that has an online network directory shall:
1. Update the online directory at least monthly;
2. Make the online directory easy to use and user friendly; and
3. Explain, in the online directory, how an enrollee or prospective enrollee can obtain a paper directory.

R20-6-1913. Demographic Information Reports

A. An HCSO shall report the following data to the Department:
1. For each enrollee, report annually:
   a. Street address,
   b. Zip code,
   c. Gender, and
   d. Year of birth.
2. For all contracted providers, report semiannually:
   a. Provider name,
   b. Street address or addresses at which the provider provides covered services,
   c. Zip code, and
   d. Arizona license number,
3. For all contracted physicians or practitioners, report semiannually:
   a. Specialty, and
   b. Medical or other applicable degree or information that designates the type of physician or practitioner.

B. The HCSO shall report the information in subsection (A) to the Department by the following deadlines:
1. For information in subsection (A)(1) as of December 31 of each calendar year, by February 15 of the next calendar year.
2. For information in subsection (A)(2) as of June 30, by August 15 of the same calendar year.
3. For information in subsection (A)(2) as of December 31, by February 15 of the next calendar year.

R20-6-1914. Access

An HCSO shall provide to or arrange for its enrollees services or appointments for services as follows:

1. For preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule.
2. For routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request to the PCP or sooner if medically necessary.
3. For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary.
4. In-area urgent care services from a contracted provider seven days per week.
5. Timely non-emergency inpatient care services from a contracted facility.
6. Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care.
7. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.

R20-6 1915. Alternative Access

A. As an alternative to providing access to covered services from a physician, an HCSO may provide access to covered services from an appropriately licensed practitioner.

B. As an alternative to providing access to covered services at a hospital under R20-6-1914, an HCSO may provide access to covered services at another appropriately licensed facility.

C. As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person under R20-6-1914, an HCSO may provide access to necessary covered services through:

1. Telephone calls and messages,
2. Electronic mail,
3. Communication with the physician's or practitioner's staff,
4. Coverage by another physician or practitioner, or
5. Telemedicine,

D. An HCSO that panels enrollees to PCPs may panel enrollees to appropriately licensed practitioners.

R20-6-1916. Availability Ratios

A. An HCSO shall maintain a ratio of contracted adult PCPs to adults that is adequate to provide those adults with covered services. An HCSO with a Medicare Advantage (MA) plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

B. An HCSO shall maintain a ratio of contracted pediatric PCPs to children that is adequate to provide those children enrollees with covered services.

C. An HCSO shall maintain a ratio of contracted high profile SCPs to enrollees that is adequate to provide those enrollees with covered services that include services at contracted facilities. An HCSO with a MA plan may have one ratio that applies to both its insured and MA populations, or a separate ratio for each.

R20-6-1917. Geographic Availability in an Urban Area

An HCSO shall provide each enrollee living in an urban area of the HCSO's service area the following:

1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and
3. Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home.

R20-6-1918. Geographic Availability in a Suburban Area

Each HCSO shall provide each enrollee member living in a suburban area within the HCSO's service area the following:

1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home;
2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and
3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home.

R20-6-1919. Geographic Availability in a Rural Area

An HCSO shall provide each enrollee living in a rural area with primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.

R20-6-1920. Travel Requirements

A. An HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. Nothing in this Section creates an exception to R20-6-1918 through R20-6-1920.

B. If the HCSO prior-authorizes services that require an enrollee to travel outside the HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses. Except as provided under R20-6-1904(E)(6), an HCSO is not required to reimburse an enrollee for travel expenses the enrollee incurs to obtain covered services in-area.

R20-6-1921. Enforcement Consideration

In determining the appropriate enforcement action or penalties for failure to comply with these rules, the Department shall consider any documentation the HCSO provides regarding:

1. Whether seasonal shifts in demand affect access and availability of covered services;
2. Whether the HCSO's demographic information has changed significantly since the HCSO's most recent report;
3. Whether an enrollee has refused to accept covered services the HCSO has offered in the time-frames or locations required of the HCSO by this Article;
4. Whether an enrollee has requested and obtained covered services from a contracted provider whose location, or appointment availability, or capacity result in the HCSO's non-compliance; and
5. Whether market factors indicate that on a short-term basis, compliance is not possible. Market factors includes shortage of providers, enrollee or provider location, and provider practice or contracting patterns.