NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES
NONCOMMUNICABLE DISEASES

[R07-16]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-4-501	Amend
R9-4-502	Repeal
R9-4-502	New Section
R9-4-503	New Section
R9-4-504	New Section

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

Authorizing statute: A.R.S. § 36-136(A)(7) and (F)

Implementing statute: A.R.S. § 36-133

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 1564, May 12, 2006

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

Name: Allison Varga James, Program Manager

Address: Arizona Department of Health Services
Bureau of Public Health Statistics
Arizona Birth Defects Monitoring Program
150 N. 18th Ave., Ste. 550
Phoenix, AZ 85007

Telephone: (602) 542-7335

Fax: (602) 542-7447

E-mail: jamesa@azdhs.gov

or

Name: Kathleen Phillips, Rules Administrator

Address: Arizona Department of Health Services
Office of Administrative Rules
1740 W. Adams, Ste. 200
Phoenix, AZ 85007

Telephone: (602) 542-1264

Fax: (602) 364-1150

E-mail: phillik@azdhs.gov

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

A.R.S. § 36-133 requires the Arizona Department of Health Services (Department) to develop a birth defects registry for the collection, management, and analysis of information on the incidence of birth defects in Arizona. Arizona Administrative Code Title 9, Chapter 4, Article 5 implements that statute by providing definitions and reporting requirements for hospitals, genetic testing facilities, prenatal diagnostic facilities, and Children's Rehabilitative Services (CRS) to follow when reporting birth defect cases or responding to requests for information from the Department. The rules allow the Department to collect information needed to monitor incidence patterns; identify population subgroups at risk; analyze data relating to the detection, diagnosis, and treatment of persons with birth defects; and identify areas that need intervention or prevention programs. Data collected may also be used to perform studies and to provide epidemiological information to the medical community.

This rulemaking corrects awkward syntax, unclear reporting requirements, ineffective organization, and undefined words and phrases in the current rules. R9-4-501 contains definitions used in Article 5 and is being amended to add definitions, such as "high-risk perinatal practice," "clinic," and "patient," to clarify the meaning of the rules. R9-4-502 specifies what information different reporting sources are required to submit to the Department and the time periods for submission. The revised rules add high-risk perinatal practices to the reporting sources; remove CRS from the reporting sources, but include CRS-contracted facilities as clinics; specify that genetic testing facilities and prenatal diagnostic facilities must submit information to the Department, rather that just allow the Department access to records; and specify what each reporting source needs to report to the Department and the reporting time-frame. R9-4-503 specifies what persons are required to allow the Department access to records, what types of documents the Department may review, and what information the Department may collect.

R9-4-504 specifies that the Department, for data quality assurance purposes**,** may request from a reporting source additional information for an incomplete report or the correction of an incorrect report, and that the reporting source is required to return a revised report to the Department within 15 business days or by a date agreed to by the reporting source and the Department. R9-4-504 also specifies that the Department may discuss information reported to or collected by the Department with others to get additional information.

All changes conform to current rulemaking format and style requirements of the Governor's Regulatory Review Council and the Office of the Secretary of State.

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

The Department did not review or rely on any study related to this rulemaking package.

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

Not applicable

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

As used in this summary, annual costs/revenues are designated as minimal when less than $1,000, moderate when between $1,000 and $10,000, and substantial when greater than $10,000. Costs are listed as significant when meaningful or important, but not readily subject to quantification.

Government entities affected by the rulemaking are the Department and CRS. The Department may bear a minimal-to-moderate cost and is expected to benefit to a moderate degree from the rulemaking. Under the current rules, CRS is required to allow the Department access to records. This specific requirement is deleted from the proposed rules, but facilities under contract with the Department to provide CRS-related services will still be required to allow the Department access to records since the definition of clinic is revised to include these facilities. This change is not expected to cause either a benefit or an additional cost to facilities under contract with the Department to provide CRS-related services.

Small businesses affected by the rules changes include genetic testing facilities; prenatal diagnostic facilities; high-risk perinatal practices; the practices of physicians, midwives, registered nurse practitioners, and physician assistants; clinics other than high-risk perinatal practices; clinical laboratories other than genetic testing facilities; and medical examiners. Under the current rules, genetic testing facilities and prenatal diagnostic facilities are required to allow the Department access to records. The proposed rules also require genetic testing facilities and prenatal diagnostic facilities to submit information to the Department about individuals for whom specific tests were performed. Genetic testing facilities and prenatal diagnostic facilities already send a copy of test results to a patient's physician, and may satisfy the proposed reporting requirement by sending to the Department a copy of the same report sent to the patient's physician. The Department expects a genetic testing facility or a prenatal diagnostic facility to incur minimal costs associated with this rulemaking.

High-risk perinatal practices are clinics or physicians that routinely provide medical services prenatally to patients or the mothers of patients who have perinatal risk factors, in order to prevent, clinically evaluate, diagnose, or treat the patient for a possible birth defect. Since high-risk perinatal practices may diagnose a patient prenatally for a possible birth defect, some high-risk perinatal practices are required under the current rules for prenatal diagnostic facilities to allow the Department access to review records. Under the proposed rules, high-risk perinatal practices would be

required to allow the Department access to records and to submit to the Department, in a format specified by the Department, a monthly report for patients or the mothers of patients whose medical records contain a diagnosis or the corresponding ICD-9-CM diagnosis code that indicates the possibility of a patient having a specific birth defect. The Department will use this information to assist in determining whether the patient has a birth defect and collect information related to the birth defect. The Department expects a high risk perinatal practice to incur minimal costs associated with this rulemaking.

Under the current rules, hospitals are required to allow the Department to review records and record information about patients. Hospitals are also required to prepare a report for the Department, upon request, in whatever format the hospital prefers, for patients with specific ICD-9-CM diagnosis codes. Hospitals currently send the prepared report to the Department each month. The proposed rules will require hospitals to prepare and submit a monthly report in a format specified by the Department, containing the information specified in the rules, for patients with specific ICD-9-CM diagnosis or procedure codes. The proposed rules also require hospitals to allow the Department to review records specified in the rules to gather information concerning a patient with a possible birth defect, and clarify the types of records that may be reviewed by the Department. The Department expects a hospital to incur minimal-to-moderate costs associated with this rulemaking. A hospital may also benefit from the rulemaking to a minimal-to-moderate degree since the Department expects record review to be a more efficient and timely process under the proposed rules.

Under the proposed rules, physicians, midwives, registered nurse practitioners, physician assistants, clinics other than high-risk perinatal practices, clinical laboratories other than genetic testing facilities, and medical examiners are required to allow the Department to review records specified in the rules to gather information concerning a patient with a possible birth defect. The Department has collected information from geneticists for 20 years and does not anticipate any additional costs to geneticists under the proposed rules. The Department expects to obtain just a small amount of missing information from physicians other than geneticists, midwives, registered nurse practitioners, physician assistants, clinics other than high-risk perinatal practices, clinical laboratories other than genetic testing facilities, and medical examiners, with the bulk of the information about birth defects being collected from hospitals and other reporting sources, geneticists, and data sources within the Department. Therefore, the Department expects that a physician other than a geneticist, midwife, registered nurse practitioner, physician assistant, clinic other than a high-risk perinatal practice, clinical laboratory other than a genetic testing facility, or medical examiner will incur minimal costs associated with this rulemaking and may even benefit from the more complete reporting from other sources that is anticipated under the proposed rules.

Parents or guardians of children who have birth defects may benefit significantly from programs developed on the basis of complete and timely reporting of birth defects. The information gathered and compiled by the Department may be used by researchers to perform studies and may be used by other health care professionals to provide intervention programs for individuals with birth defects. The Department expects the public to benefit significantly from a complete population-based birth defects reporting system that may assist in the development of programs and the allocation of resources to provide services for children who have birth defects or their families. Such programs may lead to a reduction in the number of individuals who are born with birth defects and an increase in the number of children who are connected with services that may assist them to lead more productive lives. All of these activities are anticipated to increase the number of children who will grow into tax-paying adults, instead of requiring constant medical attention and supervision at public expense.

The Department has determined that the benefits related to public health outweigh any potential costs associated with this rulemaking.

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

Name:	Allison Varga James, Program Manager
Address:	Arizona Department of Health Services Bureau of Public Health Statistics Arizona Birth Defects Monitoring Program 150 N. 18th Ave., Ste. 550 Phoenix, AZ 85007
Telephone:	(602) 542-7335
Fax:	(602) 542-7447
E-mail:	jamesa@azdhs.gov
or	
Name:	Kathleen Phillips, Rules Administrator
Address:	Arizona Department of Health Services Office of Administrative Rules

1740 W. Adams, Ste. 200
Phoenix, AZ 85007

Telephone: (602) 542-1264

Fax: (602) 364-1150

E-mail: phillik@azdhs.gov

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

The Department has scheduled the following oral proceeding:

Date: March 12, 2007
Time: 1:00 p.m.
Location: 150 N. 18th Ave., Rm. 540A
Phoenix, AZ 85007
Close of record: 4:00 p.m., March 12, 2007

A person may submit written comments on the proposed rules no later than the close of record to either of the individuals listed in items 4 and 9.

A person with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting Ruthann Smejkal at (602) 364-3959 or smejkar@azdhs.gov. Requests should be made as early as possible to allow time to arrange the accommodation.

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

Not applicable

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

Not applicable

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES
NONCOMMUNICABLE DISEASES

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

Section
R9-4-501. Definitions
R9-4-502. ~~Procedures; Permission to Review Patient Records~~ Reporting Sources; Information Submitted to the Department
R9-4-503. Review of Records; Information Collected
R9-4-504. Data Quality Assurance

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

R9-4-501. Definitions

In this Article, unless otherwise specified:

~~1. "ABDMP" means the Arizona Birth Defects Monitoring Program within the Department.~~
1. "Admitted" means the same as in A.A.C. R9-10-201.
~~2. "Birth defect" means an abnormality of structure, function, body chemistry, or gene present at or before birth, which may be diagnosed before or at birth, or later in life.~~
2. "Birth defect" means an abnormality:
   a. Of body structure, function, or chemistry, or of chromosomal structure or composition;
   b. That is present at or before birth; and
   c. That may be diagnosed before or at birth, or later in life.
3. "Business day" means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
4. "Calendar day" means any day of the week, including a Saturday or a Sunday.
5. "Clinic" means a:

a. A person under contract or subcontract with CRS to provide the medical services specified in 9 A.A.C. 7, Article 4;
b. An outpatient treatment center, as defined in A.A.C. R9-10-101, or
c. An outpatient surgical center, as defined in A.A.C. R9-10-101.

6. "Clinical evaluation" means an examination of the body of an individual and review of the individual's laboratory test results to determine the presence or absence of a medical condition.
7. "Clinical laboratory" means a facility that:
   a. Meets the definition in A.R.S. § 36-451;
   b. Is operated, licensed, or certified by the U.S. government; and
   c. Is located within Arizona.
8. "Code" means a single number or letter, a set of numbers or letters, or a set of both numbers and letters, that represents specific information.
9. "Conception" means the formation of an entity by the union of a human sperm and ovum, resulting in a pregnancy.
10. "Co-twin" means a sibling of a patient, who was born to the same mother as a result of the same pregnancy as the patient.
~~3.~~11. "CRS" means the Children's Rehabilitative Services program, established within the Department as specified in A.R.S. Title 36, Chapter 2, Article 3.
12. "Date of first contact" means the day, month, and year a physician, clinic, or other person specified in R9-4-503(A) first began to provide medical services, nursing services, or health-related services to a patient or the patient's mother.
13. "Date of last contact" means the day, month, and year:
   a. Of a patient's death; or
   b. That a physician, clinic, or other person specified in R9-4-503(A) last clinically evaluated, diagnosed, or provided treatment to a patient or the patient's mother.
14. "Designee" means an individual assigned by the governing power of a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility or by another individual acting on behalf of the governing power to gather information for or report to the Department, as specified in R9-4-502, R9-4-503, or R9-4-504.
15. "Discharge" means the same as in A.A.C. R9-10-201.
16. "Discharge date" means the month, day, and year of an individual's discharge from a hospital.
17. "Electronic" means the same as in A.R.S. § 44-7002.
18. "Enrolled" means approved to receive services specified in 9 A.A.C. 7 from CRS.
19. "Estimated date of confinement" means an approximation of the date on which a woman will give birth, based on the clinical evaluation of the woman.
20. "Estimated gestational age" means an approximation of the duration of a pregnancy, based on the date of the last menstrual period of the pregnant woman.
21. "Facility" means a building and associated personnel and equipment that perform a particular service or activity.
22. "Family medical history" means an account of past and present illnesses or diseases experienced by individuals who are biologically related to a patient.
23. "Follow-up services" means activities intended to assist the parent or guardian of a patient who has a birth defect to:
   a. Learn about the birth defect and, if applicable, how the birth defect may be prevented; or
   b. Obtain applicable medical services, nursing services, health-related services, or support services.
24. "Genetic condition" means a disease or other abnormal state present at birth or before birth, as a result of an alteration of DNA, that impairs normal physiological functioning of a human body.
~~4. "Genetic testing facility" means an organization, institution, corporation, partnership, business, or entity that conducts tests to analyze and diagnose a genetic condition in a human being.~~
25. "Genetic testing facility" means an organization, institution, corporation, partnership, business, or entity that conducts tests to detect, analyze, or diagnose a genetic condition in an individual, including an evaluation to determine the structure of an individual's chromosomes.
26. "Governing power" means the individual, agency, group, or corporation appointed, elected, or otherwise designated, in which the ultimate responsibility and authority for the conduct of a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility are vested.
27. "Guardian" means an individual appointed as a legal guardian by a court of competent jurisdiction.
28. "Health-related services" means the same as in A.R.S. § 36-401.
29. "High-risk perinatal practice" means a clinic or physician that routinely provides medical services prenatally to a patient or a patient's mother with perinatal risk factors to prevent, clinically evaluate, diagnose, or treat the patient for a possible birth defect.
30. "Log" means a chronological list of individuals for or on whom medical services, nursing services, or health-related services were provided by a designated unit of a hospital or by another person specified in R9-4-503(A).
31. "Medical condition" means a disease, injury, other abnormal physiological state, or pregnancy for which an individual may seek medical services or nursing services.

32. "Medical record" means the same as in A.R.S. § 12-2291.
33. "Medical record number" means a unique number assigned by a hospital, clinic, physician, or registered nurse practitioner to an individual for identification purposes.
34. "Medical services" means the same as in A.R.S. § 36-401.
35. "Midwife" means an individual licensed under A.R.S. Title 36, Chapter 6, Article 7, or certified under A.R.S. Title 32, Chapter 15.
36. "Mother" means the woman:
    a. Who is pregnant with or gives birth to a patient, or
    b. From whose fertilized egg a patient develops.
37. "Multiple gestation" means a pregnancy in which a patient is not the only fetus carried in a mother's womb.
38. "Nursing services" means the same as in A.R.S. § 36-401.
39. "Ordered" means instructed by a physician, registered nurse practitioner, or physician assistant to perform a test on an individual.
40. "Parent" means the:
    a. Biological or adoptive father of an individual; or
    b. Woman who:
        i. Is the mother of an individual; or
        ii. Adopts an individual.
41. "Pathology laboratory" means a facility in which human cells, body fluids, or tissues are examined for the purpose of diagnosing diseases and that is licensed under 9 A.A.C. 10, Article 1.
~~5. "Patient" means an individual admitted to or receiving care in a hospital, genetic testing facility, prenatal diagnostic facility, or the CRS.~~
42. "Patient" means an individual, regardless of current age, who, from conception to one year of age, was or whose mother was:
    a. Clinically evaluated for a possible birth defect or a medical condition that may be related to a birth defect:
        i. By:
            (1) A physician;
            (2) A midwife;
            (3) A registered nurse practitioner; or
            (4) A physician assistant; or
        ii. At a hospital or clinic;
    b. Tested by a:
        i. Genetic testing facility or other clinical laboratory, or
        ii. Prenatal diagnostic facility; or
    c. Provided treatment by a hospital, clinic, physician, registered nurse practitioner, or other person specified in R9-4-503(A) for a medical condition that may be related to a possible birth defect.
43. "Perinatal risk factor" means a situation or circumstance that may increase the chance of an individual being born with a birth defect, such as:
    a. A family medical history of birth defects or other medical conditions;
    b. The exposure of the individual or the individual's mother or biological father to radiation, medicines, chemicals, or diseases before the individual's birth; or
    c. An abnormal result of a test performed for the individual or the individual's mother by a prenatal diagnostic facility or clinical laboratory, including a genetic testing facility.
~~6. "Personal identifiers" means confidential information that can be solely attributed to a specific individual.~~
44. "Physician assistant" means an individual licensed under A.R.S. Title 32, Chapter 25.
~~7.~~45. "Prenatal diagnostic facility" means an organization, institution, corporation, partnership, business, or entity that conducts diagnostic ultrasound or other medical procedures that may diagnose a birth defect in a human being.
46. "Principal diagnosis" means the primary reason for which an individual is:
    a. Admitted to a hospital;
    b. Treated by a hospital, clinic, physician, registered nurse practitioner, or physician assistant; or
    c. Tested by a genetic testing facility or prenatal diagnostic facility.
47. "Procedure" means a set of activities performed on a patient or the mother of a patient that:
    a. Are invasive in nature;
    b. Are intended to diagnose or treat a disease, illness, or injury;
    c. Involve a risk to the patient or patient's mother from the activities themselves or from anesthesia; and
    d. Require the individual performing the set of activities be trained in the set of activities.
48. "Refer" means to provide direction to an individual or the individual's parent or guardian to obtain medical services or a test for assessment, diagnosis, or treatment of a birth defect or other medical condition.
49. "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in

A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.

~~8. "Reporting source" means a hospital, genetic testing facility, prenatal diagnostic facility, or the CRS.~~

50. "Routinely" means occurring in the regular or customary course of business.
51. "Secondary diagnosis" means all other diagnoses for an individual besides the principal diagnosis.
52. "Singleton gestation" means a pregnancy in which a patient is the only fetus carried in a mother's womb.
53. "Support services" means activities, not related to the diagnosis or treatment of a birth defect, intended to maintain or improve the physical, mental, or psychosocial capabilities of a patient or those individuals biologically or legally related to the patient.
54. "Surgical procedure" means making an incision into an individual's body for the:
    a. Correction of a deformity or defect,
    b. Repair of an injury,
    c. Excision of a part of the individual's body, or
    d. Diagnosis, amelioration, or cure of a disease.
55. "Test" means:
    a. An analysis performed on body fluid, tissue, or excretion by a genetic testing facility or other clinical laboratory to evaluate for the presence or absence of a disease; or
    b. A procedure performed on the body of a patient or the patient's mother that may be used to evaluate for the presence or absence of a birth defect.
56. "Transfer" means for a hospital to discharge a patient or the patient's mother and send the patient or the patient's mother to another hospital for inpatient medical services without the intent that the patient or the patient's mother will return to the sending hospital.
57. "Treatment" means the same as in A.A.C. R9-10-101.
58. "Unit" means an area of a hospital designated to provide an organized service, as defined in A.A.C. R9-10-201.

R9-4-502. ~~Procedures; Permission to Review Patient Records~~ Reporting Sources; Information Submitted to the Department

~~**A.** A reporting source providing care to an individual from fertilization to one year of age who has been diagnosed as having a birth defect shall permit the ABDMP to review and record personal identifiers, demographic, and diagnostic data from:~~

~~1. The following documents pertaining to the individual and the individual's mother:~~
~~a. Disease indices,~~
~~b. Intensive care unit logs,~~
~~c. Pathology-autopsy logs for stillbirths,~~
~~d. Patient medical records, and~~
~~e. Laboratory reports pertaining to chromosomal analysis and tests for detection of hereditary biochemical disorders.~~
~~2. The labor and delivery logs and the ultrasound logs for the individual's mother.~~

~~**B.** A hospital shall prepare a disease index listing an ICD-9-CM diagnosis code for each patient identified in subsection (A) arranged in ascending order. Next to each ICD-9-CM diagnosis code listed in the index, the hospital shall provide the following information:~~

~~1. Whether the diagnosis code reflects a principal or secondary diagnosis,~~
~~2. The age of the patient,~~
~~3. The dates of admission and discharge, and~~
~~4. The patient's medical record number.~~

~~**C.** A reporting source shall permit ABDMP to review the documents listed in subsections (A) once every 30 days.~~

A. The designee of a hospital shall:
1. Prepare a written report each month in a format provided by the Department of all individuals:
    a. Who are patients or the mothers of patients, and
    b. Whose:
        i. Discharge date is within the month for which the report is being prepared, as specified in subsection (A)(2)(d), and
        ii. Medical record includes for the principal diagnosis, a secondary diagnosis, or a procedure performed on the individual, an ICD-9-CM diagnosis or procedure code specified in a list provided to the hospital by the Department;
2. Include the following information in the report specified in subsection (A)(1):
    a. The name, address, and telephone number of the hospital, or the identification number assigned by the Department to the hospital;
    b. The name and telephone number of the designee of the hospital;
    c. The date the report was completed;
    d. The month for which the report is being prepared; and

e. For each patient or the mother of the patient:
i. The patient's or mother's medical record number;
ii. The name of the patient or patient's mother, if available, and, if applicable, any other name by which the patient or patient's mother is known;
iii. The race and ethnicity of the patient or patient's mother;
iv. The patient's gender and date of birth, if applicable;
v. The admission and discharge dates;
vi. The principal and secondary diagnoses or the ICD-9-CM diagnosis codes for the principal and secondary diagnoses for the patient or patient's mother; and
vii. The procedure codes for the patient or patient's mother; and

3. Submit the report specified in subsection (A)(1) for the month identified as specified in subsection (A)(2)(d) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

B. The designee of a high-risk perinatal practice shall:

1. Prepare a written report each month in a format provided by the Department of all individuals:
a. Who are patients or the mothers of patients, and
b. Whose:
i. Date of last contact is within the month for which the report is being prepared, as specified in subsection (B)(2)(d), and
ii. Medical record includes a principal or secondary diagnosis specified in a list provided to the high-risk perinatal practice by the Department;

2. Include the following information in the report specified in subsection (B)(1):
a. The name, address, and telephone number of the high-risk perinatal practice, or the identification number assigned by the Department to the high-risk perinatal practice;
b. The name and telephone number of the designee of the high-risk perinatal practice;
c. The date the report was completed;
d. The month for which the report is being prepared; and
e. For each patient or the mother of the patient:
i. The patient's or mother's medical record number, if assigned;
ii. The mother's name;
iii. The mother's date of birth;
iv. The mother's estimated date of confinement;
v. The patient's gender, if known;
vi. Whether the patient is from a singleton or multiple gestation;
vii. The location and date of the patient's birth, if known;
viii. Whether the patient was born alive or dead, if known;
ix. The date of last contact with the mother;
x. The principal and secondary diagnoses for the patient or the patient's mother; and
xi. If the principal and secondary diagnoses for the patient were made before the patient's birth, whether the principal and secondary diagnoses were confirmed at birth; and

3. Submit the report specified in subsection (B)(1) for the month identified as specified in subsection (B)(2)(d) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

C. The designee of a genetic testing facility shall:

1. Prepare a written report each month, in a format provided by the Department, of all individuals:
a. Who are patients or the mothers of patients, and
b. For whom the genetic testing facility performed a test:
i. Completed within the month for which the report is being prepared, as specified in subsection (C)(2)(d); and
ii. Specified in a list provided by the Department to the genetic testing facility;

2. Include the following information in the report specified in subsection (C)(1):
a. The name, address, and telephone number of the genetic testing facility, or the identification number assigned by the Department to the genetic testing facility;
b. The name and telephone number of the designee of the genetic testing facility;
c. The date the report was completed;
d. The month for which the report is being prepared; and
e. For each patient or mother of a patient:
i. If the test was performed on the patient:
(1) The patient's name, date of birth, and gender; and
(2) The name of the patient's parent or guardian;

ii. If the test was performed on the mother of the patient:
(1) The mother's name and date of birth;
(2) The estimated gestational age of the patient when the test was performed, if available; and
(3) The mother's estimated date of confinement when the test was performed, if available;
iii. The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the patient or the patient's mother; and
iv. Information about the test, including:
(1) The type of test performed on the patient or the patient's mother,
(2) The date the test was completed, and
(3) The results of the test; and

3. Submit the report specified in subsection (C)(1) for the month identified as specified in subsection (C)(2)(d) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

D. The designee of a prenatal diagnostic facility shall:
1. Submit an electronic or paper report to the Department:
a. For each mother:
i. On whom the prenatal diagnostic facility conducts a test specified in a list provided by the Department to the prenatal diagnostic facility; and
ii. Whose test result indicates a diagnosis specified in a list provided by the Department to the prenatal diagnostic facility; and
b. Within 30 calendar days from the date of the test;
2. Include the following information in the report specified in subsection (D)(1):
a. The name, address, and telephone number of the prenatal diagnostic facility, or the identification number assigned by the Department to the prenatal diagnostic facility;
b. The name and telephone number of the designee of the prenatal diagnostic facility;
c. The date the report was completed;
d. The mother's name and date of birth;
e. The estimated gestational age of the patient at the time of the test;
f. The mother's estimated date of confinement;
g. The outcome of the pregnancy, if known;
h. The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the mother; and
i. Information about the test, including:
i. The type of test performed on the mother,
ii. The date the test was completed, and
iii. The results of the test.

R9-4-503. Review of Records; Information Collected

A. Upon notice from the Department of at least five business days, the following persons or facilities shall allow the Department access to the facility and the electronic or written records specified in subsection (B)(1) to collect the information specified in subsection (B)(2):
1. A hospital,
2. A clinic,
3. A physician,
4. A midwife,
5. A registered nurse practitioner,
6. A genetic testing facility,
7. A prenatal diagnostic facility,
8. A physician assistant,
9. A clinical laboratory, or
10. A medical examiner.

B. The Department may:
1. Review any of the following records in electronic or written format, as are applicable to the person or facility specified in subsection (A):
a. Patient medical records;
b. Medical records for the mother of a patient;
c. Reports from:
i. Physicians or other individuals who clinically evaluated, diagnosed, or treated a patient or the patient's mother,

ii. High-risk perinatal practices,
iii. Prenatal diagnostic facilities,
iv. Genetic testing facilities,
v. Pathology laboratories, or
vi. Other facilities or clinical laboratories that performed a test for a patient or the patient's mother;
d. Logs containing information about surgical procedures, as specified in A.A.C. R9-10-214(A)(6) or A.A.C. R9-10-1709(A);
e. Other logs that may contain information about a patient or the mother of a patient with a birth defect, such as:
i. Labor and delivery unit logs,
ii. Nursery unit logs,
iii. Pediatric unit logs,
iv. Intensive care unit logs,
v. Autopsy logs, and
vi. Ultrasound logs;
f. Autopsy reports; and
g. Records other than those specified in subsections (B)(1)(a) through (f) that contain information about or may lead to information about:
i. A patient,
ii. The patient's mother, or
iii. The patient's biological sibling; and
2. Collect the following information, as are applicable to a patient or the mother of a patient:
a. The name, address, and telephone number of the person or facility, or the identification number assigned by the Department to the person or facility;
b. The date of first contact and the date of last contact;
c. The date the patient was admitted to a hospital;
d. The date the patient was discharged from a hospital;
e. The dates the mother of the patient was admitted to and discharged from a hospital for:
i. The birth of the patient; or
ii. Treatment related to a possible birth defect in the patient;
f. The name and address of the hospital or other location in which the patient was born;
g. The name and address of a hospital in which the patient or the mother of the patient was admitted for treatment related to a possible birth defect in the patient;
h. The specific unit of a hospital that provided medical services to the patient or the patient's mother;
i. The medical record number of the patient or the patient's mother;
j. The patient's name and any other name by which the patient is known;
k. The names, addresses, and dates of birth of the patient's parents;
l. The name, address and telephone number of the patient's guardian, if a parent of the patient does not have physical custody of the patient;
m. The patient's date of birth and hour of birth;
n. The estimated date of confinement for the pregnancy resulting in the patient's birth;
o. The estimated gestational age, length, weight, and head circumference of the patient at birth;
p. The patient's gender, race, and ethnicity;
q. The race and ethnicity of the patient's biological mother and father;
r. The address of the patient's mother at the time of the patient's birth;
s. The address and telephone number of the patient at the date of last contact;
t. The county in which the patient was born;
u. The name of each physician, registered nurse practitioner, physician assistant, or other person that clinically evaluated, diagnosed, ordered a test for, or treated the patient or the patient's mother;
v. The names of any facility from which or to which the patient or the patient's mother was transferred or referred;
w. Whether the patient was referred to or is enrolled in CRS and, if so, the date of referral or enrollment;
x. Whether the patient is receiving any other follow-up services, medical services, nursing services, or health-related services related to a birth defect, and, if so, the name of the person providing the services and the date the provision of the services began;
y. The name of the insurance company, if applicable, that:
i. Paid for the birth of the patient, and
ii. Is currently covering medical expenses for the patient or the patient's mother;
z. Any perinatal risk factors documented in:
i. The patient's medical record,
ii. The patient's mother's medical record, or

iii. The patient's family medical history;

aa. Whether any tests were performed on the patient or the patient's mother by a genetic testing facility and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The age or estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient's mother at the time of each test,
  vi. The name of the genetic testing facility that performed each test; and
  vii. The names of the individuals who interpreted the test results;

bb. Whether any tests were performed on the patient or the patient's mother by a prenatal diagnostic facility and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient's mother at the time of each test,
  vi. The name of the prenatal diagnostic facility that performed each test; and
  vii. The names of the individuals who interpreted the test results;

cc. Whether any other types of tests were performed on the patient or the patient's mother that may enable the diagnosis of a birth defect and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The age or estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient's mother at the time of each test,
  vi. The names of the facilities that performed the tests; and
  vii. The names of the individuals who interpreted the test results;

dd. Whether any surgical procedures associated with a birth defect were performed on the patient or the patient's mother and, if so:
  i. The types of surgical procedures performed,
  ii. The dates of the surgical procedures,
  iii. The results of the surgical procedures,
  iv. The ages or estimated gestational ages of the patient at the time of the surgical procedures,
  v. The estimated date of confinement of the patient's mother at the times of the surgical procedures, and
  vi. The names of the facilities at which the surgical procedures were performed; and
  vii. The names of the individuals who performed the surgical procedures;

ee. For each diagnosis made for the patient or the patient's mother:
  i. The diagnosis,
  ii. Whether the diagnosis is a principal or secondary diagnosis,
  iii. The facility at which the diagnosis was made,
  iv. The date on which the diagnosis was made, and
  v. The name of the individual who made the diagnosis;

ff. The number of times the patient's mother has been pregnant;

gg. The number of times a pregnancy of the patient's mother has lasted:
  i. More than 37 weeks,
  ii. Between 20 and 37 weeks, and
  iii. Less than 20 weeks;

hh. The number of children who were born as a result of the patient's mother's pregnancies, and whether the children were born alive or dead;

ii. Whether the patient is from a singleton or multiple gestation, and, if from a multiple gestation, whether a co-twin of the patient:
  i. Is identical or fraternal,
  ii. Is alive, and, if not alive, the co-twin's date of death; and
  iii. Has:
    (1) The same birth defect as the patient,
    (2) A different birth defect from that of the patient, or
    (3) No birth defect;

jj. If the patient is being adopted or living with a guardian rather than a parent;

kk. If the patient is being adopted, the name, address, and telephone number of the individual who will adopt the

patient;
ll. The date of last contact; and
mm. If the patient has died:
i. The patient's date and county of death,
ii. The facility in which the patient's death occurred, and
iii. Whether an autopsy was performed on the patient.

R9-4-504. Data Quality Assurance

A. The Department may request a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility to revise a report:
1. That was submitted to the Department by the designee of the hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility under R9-4-502;
2. That was not prepared according to R9-4-502; and
3. By identifying the revisions that are needed in the report.

B. If a person receives a request from the Department for revision of a report not prepared according to R9-4-502, the person shall return a revised report, containing the revisions requested by the Department, to the Department within 15 business days after the date of the Department's request, or by a date agreed to by the person and the Department.

C. The Department may discuss the information submitted to the Department as specified in R9-4-502 or collected as specified in R9-4-503(B)(2) with any of the entities specified in R9-4-503(A) to obtain additional information about a patient's diagnosis or treatment.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R07-14]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-27-101	Amend
R9-27-202	Amend
R9-27-204	Amend
R9-27-210	Amend
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-307	Amend
R9-27-310	Amend
R9-27-311	New Section
R9-27-312	New Section
Article 4	Repeal
R9-27-401	Repeal
R9-27-509	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)

Implementing statute: A.R.S. § 36-2912(I)(5)

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

Notice of Rulemaking Docket Opening: 13 A.A.R. 209, January 26, 2007

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

Name: Jane McVay

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

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

The reasons for initiating the rulemaking are to make needed changes to the Healthcare Group rules to reflect program changes and to make the rules more clear, concise, and understandable. The rules revise definitions used in the Healthcare Group program, modify the scope of services, clarify the enrollment and eligibility criteria for employers and dependents, and modify provisions regarding termination of Healthcare Group coverage.

In 1988, the Arizona Legislature created the Healthcare Group (HCG) Program to offer health care coverage to a segment of the market, small businesses, that the Legislature felt were not adequately served by commercial insurers. Typically, commercial insurers "rate" small groups; that is, the premium for the group is based on the health histories of the individual members. As a result, the premiums for the employee with a history of illness and the other members of the group are often prohibitively expensive. Under A.R.S. § 36-2912, the Healthcare Group Program was designed to offer health coverage to small groups without "rating" prospective members based on individual histories. In effect, the risk is spread over all participants in the program equally rather than being assigned to the individual employer.

The Healthcare Group Program consists of contracts between the Health Care Group Administration (HCGA) and small employers that wish to offer, as an employment benefit, health coverage for themselves, their employees and their dependents. These contracts are known as Group Service Agreements or GSAs. HCGA has responsibility for the design of those contracts and for determining the eligibility of employers and covered persons. HCGA also establishes premium rates sufficient to cover the risk and collects those payments from the employer.

Currently, the HCG Program offers four different options to participating employers, employees, and their dependents. In general terms, these options vary based on the level of copayments, coinsurance, and deductibles, and to some extent on the scope of covered services (that is, some of the options are more comprehensive than others). Although HCGA does not consider the health history of individuals in setting premiums, each of the options has a different premium schedule that takes into consideration the age, sex, and location of the member, as well as the option selected. Individual employees of an employer can select from the available options. HCGA does not prescribe any level of employer participation in the financial cost – they may cover the cost themselves, share the cost with the employees, or simply allow payroll deduction for the employee, with the employee carrying the full cost.

In general, participation in Healthcare Group is limited to employers of fewer than 50 persons. Under the current statute, the employer must not have offered group health insurance during the 180-day period prior to HCG coverage. This limitation was designed to provide reasonable assurance to the commercial health insurance industry that the market consisted of the uninsured, thereby minimizing the loss of commercial carriers to Healthcare Group. Since July 1, 2005, the program has been funded solely by the premiums paid. Participation on both the employer level and the individual employee level is voluntary.

With respect to the actual delivery of services, HCGA currently assigns employers to a managed care entity ("health plan") under contract with HCGA, or where choice is available, allows the employer to select from HCG-contracted managed care entities. The contracts between HCGA and the health plan define the network of providers from whom service is received and the responsibility for medical management and payment of claims consistent with the terms of the health plan contract and the contract between HCGA and the employer. These health plans are "at risk"; that is, the agency pays the health plan on a per member per month basis, and in return, the health plan is obligated to cover the costs of all medical care covered under the GSA regardless of the actual cost of those services. Essentially, they operate like Health Maintenance Organizations.

At the outset of the HCG Program, the agency exercised its discretion to administer the Program in a fashion similar to the other health programs administered by the agency. At the time, all of the participating health plans also participated in the other AHCCCS programs, thus the uniformity offered the advantage of simplified administration for both the agency and its contracted health plans. During the past few years and legislative sessions, there has been a recognition that the HCG Program can more effectively meet the needs of small business through greater program flexibility. For instance, recent statutory changes permit the agency to contract directly with providers and with third parties to assist with the administration of the program. This enables the Program to offer a Preferred Provider Network ("PPO"), in addition to the closed network of the HMO-style product offered through the health plans. Under the PPO

model, the agency manages the risk itself and adjusts premiums, if necessary, through contract amendments to cover the claims experience associated with the PPO product.

Of particular importance are proposed modifications to the rules that define the scope of services offered by the Program. By statute, the agency has the discretion to establish the scope of services under the GSAs. However, the current rules restrict the program from offering a broader array of services than many employers are willing to pay for. It is also possible that the current rules could be interpreted to require the coverage of certain services that are perceived as of little value to employers or are offered under terms that make the fiscally sound premiums excessive from the employer's perspective. These proposed rules set forth the basic terms of coverage without unduly restricting or mandating services. As noted in the rules, the details of coverage are reflected in the terms of the Group Service Agreement and are described in the member handbooks that are available to prospective members and provided to all active members. In effect, these proposed rules provide notice to the public of the availability of the program, but permit the agency the flexibility to tailor health care benefit options to the needs of different segments of the target market.

Essentially, the HCG Program consists of a series of voluntary contracts between the agency and small employers, between the agency and HMO-style managed care entities, and potentially between the agency and providers and administrative entities. Under A.R.S. § 41-1005(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. Thus, rulemaking regarding this program is permitted but not mandatory. The agency's objective is to use the published rules as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contracts for details.

HCGA was created as a division within the Administration in 1988 to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or fewer employees. Only 28% of these small Arizona employers offer health care coverage to their employees. Many of these employees are low wage earners, whose income is on the verge of eligibility for AHCCCS coverage. State legislation was enacted in 2004 that allows Healthcare Group to offer health care plans to employees of political subdivisions in the state, in addition to small businesses. As of November 1, 2006, Healthcare Group provided health care coverage to 24,011 subscribers in all 15 counties in the state.

HCGA intends to offer a greater variety of affordable health care plans in order to provide health care coverage to an increasing number of employees and to help reduce the substantial number of uninsured Arizona citizens. Healthcare Group provides health care coverage in the rural areas of the state through the PPO Plan and intends to offer additional health care options in the rural areas. A greater number and more diverse types of health plans will be offered to employees, who may otherwise not have affordable health care coverage.

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

The agency did not review any study related to this rulemaking.

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

Not applicable

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

The rules are expected to have a minimal economic impact on consumers and small businesses. A minimal impact is defined as under $1,000. The rules modify definitions and other provisions relating to health care coverage available from Healthcare Group to small businesses with 1 to 50 employees, employees of political subdivisions in the state, and to persons who qualify for the federal health care coverage tax credit. The Administration will incur a minimal cost to prepare and publish the rulemaking.

The rules offer small businesses and employees who qualify for health care coverage through Healthcare Group an option to obtain affordable individual or family health care coverage, which is beneficial to the employers, employees, and their families. Now one out of every five residents, or approximately 1,000,000 Arizona residents is uninsured. Availability of this coverage allows employees and their families to obtain health care coverage rather than being uninsured or enrolling in government-subsidized coverage, such as AHCCCS or KidsCare, thereby saving taxpayers substantial amounts of both state and federal monies. Savings of state and federal dollars results due to employers and employees choosing to pay for their health care coverage rather than enrolling in government-subsidized coverage. The premium for Healthcare Group coverage is paid by the employer, the employee, or by both the employer and the employee. The Healthcare Group program does not receive any state general fund appropriations to operate the program and is self-supporting from premium collections, so there is no additional cost to the state to operate the program.

Cost savings will also accrue to hospitals due to more individuals obtaining health care coverage rather than remaining uninsured and increasing hospital uncompensated care costs when hospitalization is required. Another positive impact of increasing the number of individuals with health care coverage is the reduction of sick leave usage with no reduction in worker productivity.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the

economic, small business, and consumer impact statement:

Name: Jane McVay

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of January 22, 2007. Please send written comments to the above address by 1 p.m., March 12, 2007. E-mail comments will be accepted.

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

Date: March 12, 2007
Time: 10:00 a.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Gold Room
Nature: Public Hearing

Date: March 12, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: March 12, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
3480 E. Rte. 66
Flagstaff, AZ 86004
Nature: Public Hearing

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

Not applicable

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

Not applicable

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
~~HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED~~ HEALTHCARE GROUP COVERAGE

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-27-202. Covered Services
R9-27-204. ~~Out-of-Network Coverage of~~ Emergency Medical Services
R9-27-210. Pre-existing Conditions

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-27-301. Eligibility Criteria for ~~Employer Groups~~ Employers
R9-27-302. Eligibility and Enrollment Criteria for Employees
R9-27-303. ~~Eligibility Criteria for Dependents~~ Dependent Eligibility Criteria
R9-27-307. Enrollment; Effective Date of Coverage
R9-27-310. Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment
R9-27-311. Effective Date of Termination of HCG Coverage
R9-27-312. Continuation Coverage

~~ARTICLE 4. CONTRACTS AND GSAS~~ Repealed

Section
R9-27-401. ~~General~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-27-509. Information to ~~Enrolled Members~~ Subscribers

ARTICLE 7. STANDARD FOR PAYMENTS

Section
R9-27-702. ~~Prohibition Against Charges to Members~~ Charges to Members
R9-27-703. Payments by an HCG ~~Plans~~ Plan
R9-27-704. ~~HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members~~ Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members

ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

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

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

"Employer group"	R9-27-101
"Enrollment"	R9-27-101
~~"Evidence of coverage (EOC)"~~	~~R9-27-101~~
"Experimental ~~Services"~~ services"	R9-27-101
~~"FDA"~~	~~R9-27-101~~
"Full-time employee"	R9-27-101
"GSA"	R9-27-101
"HCG"	R9-27-101
"HCGA" ~~or "Healthcare Group Administration"~~	R9-27-101
~~"HCG benefit plan"~~	~~R9-27-101~~
"HCG Plan"	R9-27-101
"Health care coverage"	R9-27-101
"Health care practitioner"	R9-27-101
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
"Late enrollee"	R9-27-101
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101
"Member handbook and evidence of coverage" or "member handbook"	R9-27-101
"Network"	R9-27-101
"Network provider"	R9-27-101
"Political subdivision"	R9-27-101
"Post-stabilization services"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
"Prior authorization"	R9-27-101
"Qualifying event"	R9-27-101
"Scope of services"	R9-27-101
"Spouse"	R9-27-101
"Subcontract"	R9-27-101
"Subscriber"	R9-27-101
"Subscriber enrollment form"	R9-27-101
"Substantial gainful activity"	R9-27-303
"United States"	R9-27-101
"Waiting period"	A.R.S. § 36-2912

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

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

"AHCCCS" means the Arizona Health Care Cost Containment System, which provides health services to an eligible member through the Administration, contractors, and other arrangements.

~~"Coinsurance" means an amount specified in a GSA that 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.~~

"Coinsurance" means a predetermined percentage of the cost of a covered service as specified in the GSA that a member agrees to pay for the provision of that service.

~~"Copayment" means an amount specified in a GSA that a member pays directly to a provider at the time a covered service is rendered.~~

"Copayment" means a fixed-dollar amount that a member is required to pay directly to a provider at the time the services are rendered in order to receive the services.

"Covered services" means the health and medical services described in Article 2 of this Chapter, the GSA, and the member handbook.

"Day" means a calendar day unless otherwise specified.

~~"Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG Plan begins to pay.~~

"Deductible" means the annual fixed-dollar amount of covered expenses that the member must pay before the HCG Plan

starts to pay for covered services, subject to copayments and coinsurance.
"Dependent" means the eligible ~~spouse and children~~ child and spouse of ~~an employee member~~ a subscriber under Article 3 of this Chapter.
"Effective date of coverage" means the date on which ~~an employee~~ a subscriber or dependent can receive HCG coverage.
"Emergency ambulance service" means transportation by a ground or an air ambulance company for a member requiring emergency medical services in which the emergency medical services are provided by a person certified ~~by ADHS~~ or licensed by a state to provide the services before, during, or after the member is transported by a ground or an air ambulance company.
"Emergency medical services" means covered medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, may reasonably expect the absence of immediate medical attention to result in:

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

"Employee" means a person employed by an employer, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301.
"Employer" means a business within this state that employs at least one but not more than 50 eligible full-time employees on the effective date of the first GSA with an HCG Plan, or an eligible political subdivision of this state. An employer includes a person who is self-employed.
~~"Employer group" means a group or a self-employed person who meets the criteria specified in R9-27-301.~~
"Employer group" means all eligible enrolled subscribers and eligible enrolled dependents, who receive HCG coverage through a contract with the employer.
~~"Employee member" means an enrolled employee of an employer group, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301.~~
~~"Enrollment" means the process in which an eligible employee and dependents, if any, are qualified to receive HCG services by selecting an HCG benefit plan and completing and submitting all necessary documentation specified by HCGA under R9-27-302; and the HCG Plan receiving the full required premium no later than the date specified in the GSA.~~
"Enrollment" means the process in which an eligible employee and any eligible dependents are qualified to receive HCG covered services by selecting HCG coverage and completing and submitting all necessary and required documentation specified by HCGA under R9-27-302, provided that HCGA receives the full required premium for the entire employer group no later than the date specified in the employer group GSA.
~~"Evidence of Coverage (EOC)" means a document that lists covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.~~
"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:

The weight of evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or
In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.

~~"FDA" means the U.S. Food and Drug Administration.~~
"Full-time employee" means an employee or a self-employed person who works at least 20 hours per week.
"GSA" means Group Service Agreement, a contract between an employer ~~group~~ and HCGA or between HCGA and a person eligible for the federal health coverage tax credit.
~~"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.~~
~~"HCGA" or "Healthcare Group Administration" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.~~
~~"HCG benefit plan" means the scope of health care and prescription benefit coverage that a member selects on enrollment or renewal.~~
~~"HCG Plan" means a health plan offered by HCGA or by an entity that is under contract with the HCGA to provide covered or administrative services to members.~~
"HCG" means Healthcare Group of Arizona, the program within the Administration authorized by A.R.S. § 36-2912 that allows HCG Plans to provide pre-paid health care coverage to subscribers of small businesses and political subdivisions within the state of Arizona through contracts with HCGA.

"HCGA" means Healthcare Group of Arizona Administration, which directs, determines eligibility, and regulates the continuous development and operation of the HCG program.
"HCG Plan" means a health plan offered by HCGA or by an entity under contract with the HCGA that establishes net works, manages the provision of covered services, and arranges for, and pays for HCG covered services through subcontracts with providers.
"Health care coverage" means a hospital or medical service corporation policy or certificate, a health care services organization contract, a multiple-employer welfare arrangement, or any other arrangement under which health services or health benefits are provided to two or more persons. Health care coverage does not include the following:
Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage, or Taft-Hartley trusts;
Coverage that is issued as a supplement to liability insurance;
Medicare supplemental insurance;
Workers' compensation insurance; or
Automobile medical payment insurance.
"Health care practitioner" means a person who is licensed or certified under Arizona law to deliver health care services.
"Hospital" means a health care institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.
"Inpatient hospital services" means services provided to a member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.
"Late enrollee" means a member who enrolls 31 days after the effective date of the employer's initial GSA, or 31 days after a qualifying event, or outside of the open enrollment period.
"Medically necessary" means a covered service is determined by the HCG Plan or HCGA Medical Director, and a physician or other licensed health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:
Prevent disease, disability, or other adverse health condition or its progression; or
Prolong life.
~~"Member" means an employee member or a dependent who is enrolled with an HCG Plan.~~
"Member" means a subscriber and the subscriber's dependents who are enrolled with an HCG Plan for health care coverage.
~~"Member handbook" means the written description that HCGA provides to each member on enrollment, of the rights and responsibilities of members of HCG.~~
"Member handbook and evidence of coverage" or "member handbook" means the written description that HCGA provides to each subscriber on enrollment, of the rights and responsibilities of members, as well as a list of covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.
~~"Network" means the providers who have subcontracts with HCG Plans in which members are enrolled.~~
"Network" means the affiliation of physicians, hospitals and other providers that provide health care services to members through contracts with HCGA or HCG Plans.
"Network provider" means a provider who has a subcontract with ~~a member's HCG Plan~~ HCGA or an HCG Plan and renders covered services to the member.
"Political subdivision" means the state of Arizona or a county, city, town, or school district within the state, or an entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4.
"Post-stabilization services" means covered services related to an emergency medical condition provided after the condition is stabilized.
"Premium" means the entire monthly pre-payment amount due to HCGA by the employer ~~group.~~ for coverage of medical benefits for all subscribers and dependents.
"Pre-payment" means the monthly submission ~~of the employer group's~~ by the employer or any eligible employee of the full premium payment at least 30 days in advance of coverage under the GSA.
"Prior authorization" means the process by which the HCGA or the HCG Plan informs a provider that it has made a preliminary determination that a requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment
"Qualifying event" means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period without being considered a late enrollee, or to obtain continuation coverage, if applicable.
"Scope of services" means the covered, limited, and excluded services listed in Article 2 of this Chapter, the GSA, and the member handbook**.**
"Spouse" means a husband or a wife of an HCG ~~member~~ subscriber who has entered into a marriage recognized as valid

by the state of Arizona.
"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:
A provider of health care services who agrees to furnish covered services to members,
A marketing organization, or
Any other organization to serve the needs of the HCG Plan**.**
"Subscriber" means an enrolled HCG employee, including a person who meets the eligibility requirements for the federal health coverage tax credit under 26 U.S.C. 35 (Section 35 of the Internal Revenue Code of 1986).
"Subscriber enrollment form" means the form that a subscriber fills out to select and enroll in an HCG Plan and to choose a deductible.
"United States" means the 50 states, the District of Columbia, and includes the territorial waters adjoining these entities. A ship or an aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.

ARTICLE 2. SCOPE OF SERVICES

R9-27-202. Covered Services
~~Covered services. Subject to the exclusions and limitations specified in this Article, the GSA, and the member handbook, and subject to coinsurance, copayments, and deductible requirements, an HCG Plan shall cover services specified under the GSA.~~
Covered services. HCGA or an HCG Plan shall provide covered services to members as specified in the GSA.

R9-27-204. ~~Out-of-Network Coverage of~~ Emergency Medical Services
~~**A.** Emergency medical services provided outside the HCG Plan's network are covered, based on the prudent layperson standard under 42 U.S.C. 1396u-2, if:~~
~~1. The member presents for emergency medical services at a medical facility; and~~
~~2. The member or provider notifies the HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause.~~
~~**B.** Emergency ambulance services required to transport a member to a medical facility that provides emergency services are covered if the provider notifies the HCG Plan within 10 working days from the day that the member presents for emergency ambulance service. Failure to provide notice within 10 working days constitutes cause for denial of payment unless the provider shows good cause.~~
~~**C.** The financial liability of HCG for coverage for out-of-network emergency services may be limited under the terms of the GSA. Members receiving out-of-network emergency services may be financially liable to an out-of-network provider to the extent charges by the provider exceed the financial liability established in the GSA.~~
A. Emergency medical services provided at a medical facility in the United States are covered when a member presents for emergency medical services regardless of whether the services are provided within or outside the network if the member or provider notifies the selected HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause. All emergency medical services are subject to review after services are received to ensure that the services are emergent and are covered, medically necessary services.
B. Emergency medical services provided outside the United States are not covered.

R9-27-210. Pre-existing Conditions
A. Pre-existing conditions exclusions. ~~Subject to subsection (B), an HCG Plan shall not cover~~ Except as provided in subsection (B), any health and medical services related to a pre-existing condition are not covered as specified in A.R.S. § 36-2912 and the GSA.
B. Pre-existing conditions coverage. ~~An HCG Plan shall cover pre-existing conditions for the following:~~ Health and medical services relating to pre-existing conditions for the following individuals are covered:
1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the time-frames set forth in the GSA;
2. ~~An employee~~ A subscriber eligible under ~~R9-27-302(A)(1)~~ R9-27-302 who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee.

C. Credit for prior health coverage. ~~An HCG Plan shall apply~~ A member shall receive a credit toward meeting the 12-month or 18-month pre-existing condition exclusion period of one month for each month of continuous coverage that ~~an eligible employee had~~ a member received ~~under another HCG Plan~~ from HCG/HCGA or an accountable health plan under A.R.S. § 36-2912. Upon request, ~~a contracted health plan~~ an HCG Plan ~~or an accountable health plan~~ that provided continuous coverage to a person shall disclose the coverage provided.
~~**D.** Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a pre-existing condition for a late enrollee according to A.R.S. § 36-2912.~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for ~~Employer Groups~~ Employers

A. Criteria for ~~employer groups.~~ employers.

~~1. The eligibility requirements for an employer group to obtain health care coverage through an HCG Plan are as follows:~~

~~a. The employer group shall conduct business for at least 60 days within Arizona before applying to HCGA; and~~

~~b. The employer group shall conduct business in a county with an established HCG Plan.~~

~~2. An employer group shall have a minimum of one and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.~~

1. To be eligible for health care coverage through HCG, an employer shall:
   a. Conduct business in the state of Arizona for at least 60 days before applying to HCGA.
   b. Have a minimum of one (self-employed) and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.
2. R9-27-301(A)(1)(b) does not apply to political subdivisions.

B. ~~Employer group's~~ Employer's prior health care coverage. HCGA shall not enroll an employer ~~group~~ in-Healthcare Group sooner than 180 days after the date that the employer's health care coverage under an accountable health plan is discontinued. ~~An employer group's~~ An employer's enrollment in ~~Healthcare Group~~ HCG is effective on the first day of the month after the 180-day period. The 180-day enrollment restriction does not apply to an employer ~~group~~ if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

C. ~~Required enrollment of a minimum percentage of eligible employees. Other than state employees and employees of political subdivisions of the state, employers with one to 50 eligible full-time employees may contract with HCGA if the employer group:~~ Required initial enrollment of a minimum percentage of eligible employees. An employer other than a political subdivision shall meet the following enrollment percentages on the effective date of the first GSA with HCGA:

1. ~~Has five or fewer eligible full-time employees and enrolls~~ An employer with five or fewer eligible full-time employees shall enroll 100 percent of these employees in an HCG Plan, or
2. ~~Has six or more eligible full-time employees and enrolls~~ An employer with six or more eligible full-time employees shall enroll at least 80 percent of these employees in an HCG Plan.

D. Full-time employees with proof of other health care coverage. Full-time employees with proof of existing health care coverage who elect not to participate in ~~an HCG Plan~~ HCG shall not be considered when determining the required percentage of enrollees, specified in subsection (C), if the health care coverage is one of the following:

1. Group coverage provided through a spouse, parent, legal guardian; or
2. Medical assistance provided by a government-subsidized health care program; or
3. Medical assistance provided under A.R.S. § 36-2982; or
4. Individual coverage or health care coverage through another employer.

E. Post-enrollment changes in ~~group~~ employer size. Changes in ~~group~~ employer size that occur during the term of the GSA or during any renewal periods do not affect eligibility.

F. Review and verification of eligibility. ~~determination. The HCGA may conduct random reviews of an eligibility determination of an employer group and its employees.~~ HCGA may conduct random reviews for continued eligibility of an employer and the members.

R9-27-302. Eligibility and Enrollment Criteria for Employees

A. Eligibility criteria for employees. An eligible employee shall:

1. Be eligible for a federal health coverage tax credit under 26 U.S.C. 35 as specified in A.R.S. § 36-2912 (AA)(4)(d); or
2. ~~Be employed or self-employed by an eligible employer group specified in R9-27-301 for a period of at least 60 calendar days before the effective date of coverage and:~~ Be employed by an enrolled employer with a contract with HCG as specified in R9-27-301; and
   a. Work at least 20 hours per week for the ~~employer group; and~~ employer; and
   b. Meet other requirements as specified in the GSA.

B. Enrollment criteria for eligible employees. An eligible employee ~~and dependent~~ and an eligible dependent may receive HCG coverage if all of the following occur:

1. ~~The~~ An eligible employee selects ~~an HCG benefit plan;~~ health care coverage through HCG;
2. ~~The~~ An eligible employee completes and submits all necessary documentation specified by HCGA, including the ~~employee~~ subscriber enrollment ~~information~~ form and health history forms~~;~~ for the eligible employee and each applying family member; and
3. HCGA receives the full required premium no later than the date specified in the GSA.

C. After completion of the actions in subsection (B), HCGA shall send written notification of the effective date of coverage to the ~~eligible employee and dependent.~~ subscriber and dependent.

D. Eligibility for government-subsidized health care programs. ~~The~~ HCGA shall provide written information to members

who may be eligible for a government-subsidized health care program.

~~**E.** Continuation Coverage. An employee member and dependent who are entitled to continuation coverage under COBRA continuation provisions after termination of employment may retain HCG coverage until the benefit expires, the continuation coverage ends, or the premium is not paid by the employee, whichever is earlier.~~

R9-27-303. ~~Eligibility Criteria for Dependents~~ Dependent Eligibility Criteria

A. Eligible dependents. An eligible dependent of an employee member includes:
1. A legal spouse;
2. ~~Unmarried children~~ An unmarried child 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. An adopted child or a child who is placed for adoption,
   c. A step-child, or
   d. A child for whom the ~~employee member~~ subscriber or enrolled spouse is a legal guardian.
3. An unmarried child, as specified in subsection (A)(2), of any age with a disability that existed before the child's 19th birthday, as determined by HCGA through ~~its~~ the HCGA Medical Director.

B. For the purposes of this Section:
1. "Disability" means the inability to do any substantial gainful activity by reason of any impairment or combination of impairments that HCGA through the ~~HCG~~ HCGA Medical Director expects to be permanent and continuous. The impairment must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consisting of signs, symptoms, and laboratory findings, not only the member's statement of symptoms, establishes an impairment.
2. "Substantial gainful activity" means work that:
   a. Involves doing significant and productive physical or mental duties, and
   b. Is done or intended for pay or profit.

R9-27-307. Enrollment; Effective Date of Coverage

A. Enrollment. ~~A member who meets the eligibility requirements may select an HCG benefit plan under the terms and during the periods specified in the GSA, including the following situations:~~ A member who meets the eligibility requirements may select and enroll in HCG coverage under the terms of the GSA at any time. In order not to be considered a late enrollee, an eligible member shall enroll during the qualifying event periods specified in the GSA:
1. ~~When an employer member signs the GSA;~~ Within 31 days following the effective date of the initial GSA with the employer;
2. ~~When a qualifying event occurs as prescribed in the GSA;~~ Within 31 days after the qualifying event occurs;
3. When the open enrollment period occurs as specified in the GSA; or
4. ~~When the existing health care coverage for an eligible employee or any dependent terminates.~~ Within 31 days following the termination of health care coverage for an eligible subscriber or dependent.

B. Effective date of coverage. The HCGA shall establish the effective date of coverage for an employer group or ~~an employee member under an HCG benefit plan~~ a subscriber or dependent and shall provide written notice of the effective date of coverage to the ~~employee member and the employer group.~~ employer as provided under these rules.

R9-27-310. Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment

~~**A.** Termination of a member's coverage within 10 days. The HCGA or HCG Plan may terminate a member's coverage effective 10 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage to the member's last known address, for any of the following reasons:~~
~~1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward employees or agents or HCGA, an HCG Plan, network providers, or out-of-network providers.~~

~~**B.** Termination with 30-day written notice. The HCGA or an HCG plan may terminate a member's coverage effective 30 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage to the member's last known address for any of the following reasons:~~
~~1. Repeated and unreasonable demands for unnecessary medical services;~~
~~2. Failure to pay any copayment, coinsurance, or deductible;~~
~~3. Violating a material provision of the member handbook;~~
~~4. Terminating employment;~~
~~5. Change in age or other status of the member that is required for eligibility under R9-27-302;~~
~~6. Changes to the eligibility criteria for a dependent under R9-27-303;~~
~~7. Failure of the member's employer to pay the premium; or~~
~~8. Loss of the participating health plan with which the employer group is enrolled, if there is no other participating~~

~~health plan available to serve the employer group.~~

~~**C.** Effective date of termination of hospitalized member. Subject to continuation coverage as described in R9-27-302(E), on the effective date of termination of coverage, the HCG Plan has no further obligation to provide services and benefits to a member whose coverage terminates, except that a member who is an inpatient on the effective date of termination shall continue to have coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital. Coverage for all members, except a hospitalized member, shall terminate on the effective date of the termination of the employee member's coverage. For coverage of a hospitalized member to continue under this Article, HCGA shall continue to receive timely paid premiums.~~

~~**D.** Exclusion from eligibility and enrollment. The HCGA may exclude, as ineligible to enroll or re-enroll, an employer group, an employee member, or a dependent whose prior health care coverage has been terminated by an HCG Plan for any of the following reasons:~~

~~1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward employees or agents of HCGA, an HCG Plan, network providers, or out-of-network providers;~~
~~3. Repeated and unreasonable demands for unnecessary medical services;~~
~~4. Failure to pay any copayment, coinsurance, or deductible; or~~
~~5. Violating a material provision of the member handbook.~~

A. Immediate termination of a member's coverage. HCGA may terminate a member's coverage effective immediately for any of the following reasons:
1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or factors listed in A.R.S. § 36-2912 when the member applies for coverage or obtains services;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider or an out-of-network provider.

B. Written notice. For immediate termination of a member's coverage under subsection (A), HCGA shall mail a notice of termination of coverage to the member's last known address within one business day after HCGA terminates a member's coverage. The notice shall state the date and time coverage was terminated and the reason for termination.

C. Termination of a member's coverage with 30-day notice. HCGA may terminate a member's coverage 30 days from the date of the notice for any of the following reasons:
1. Repeated and unreasonable demands for unnecessary or uncovered medical services;
2. Failure to pay any copayment, coinsurance, or deductible;
3. Violation of a provision of the member handbook;
4. Termination of employment;
5. Change in status of the member that is required for eligibility under R9-27-302; or
6. Changes to the eligibility criteria for a dependent under R9-27-303.

D. Written notice. For termination of a member's coverage with 30 days notice under subsection (C), HCGA shall mail a notice of proposed termination to the member's last known address. The notice shall state the reason for proposed termination and the date coverage will be terminated.

E. Termination of an employer group. If HCGA does not receive the full premium payment from an employer for an employer group by the premium due date specified in the GSA, HCGA shall send notice of the final due date to the employer at the employer's last known address. The notice shall advise the employer that HCGA must receive the full premium payment by the final due date contained in the notice and state the reason and date for the termination of coverage for the employer group if the full premium is not received by the final due date.

F. Exclusion of member from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, any member whose prior health care coverage has been terminated by HCGA for any of the following reasons:
1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or criteria listed in R9-27-302 and R9-27-303 when the member applies for coverage or obtains services;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;
3. Repeated and unreasonable demands for unnecessary or uncovered medical services;
4. Failure to pay any copayment, coinsurance, or deductible;
5. Violating a provision of the member handbook.

G. Exclusion of an employer from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, an employer whose prior health care coverage has been terminated by HCGA for any of the following reasons:
1. Violating a provision of the GSA;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;
3. Clear and convincing evidence of fraud or misrepresentation regarding eligibility and enrollment criteria for an

employer in R9-27-301.

R9-27-311. Effective Date of Termination of HCG Coverage

A. Except as specified in subsection (B), HCG coverage for a member shall terminate on the date specified in the notice mailed to the member as provided in R 9-27-310 (B), (D), or (E).

B. HCGA shall provide and pay for health care services for a member who is an inpatient on the effective date of termination of coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary, provided that HCGA continues to receive timely paid premiums for the member. Coverage for all other members, except the member who is an inpatient, shall terminate as provided in subsection (A).

R9-27-312. Continuation Coverage

A member who is entitled to continuation coverage under A.R.S. § 36-2912(AA)(2) may retain HCG coverage until the benefit expires, the continuation coverage ends, or the premium is not paid by the member, whichever is earlier.

ARTICLE 4. ~~CONTRACTS AND GSAS~~ Repealed

R9-27-401. ~~General~~ Repealed

~~**A.** Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans under A.R.S. § 36-2912.~~

~~**B.** GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.~~

~~**C.** Contracts and GSAs. Contracts and GSAs under A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-509. Information to ~~Enrolled Members~~ Subscribers

A. Member handbook. HCGA shall produce and distribute a printed member handbook to each ~~enrolled member~~ subscriber by the effective date of coverage or as otherwise stated in ~~contract.~~ the GSA. The member handbook shall include the following:

1. A description of all available services and an explanation of any service ~~limitation,~~ limitations, exclusions from coverage, and charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating that the HCG Plan is only liable for services authorized by a member's primary care provider or the HCG Plan;
3. ~~Locations, telephone numbers, and procedures for obtaining emergency medical services;~~ Procedures for obtaining emergency medical services;
4. An explanation of the procedure for obtaining emergency medical services outside the ~~HCG Plan's service area;~~ network of an HCG Plan;
5. ~~Causes for which~~ Circumstances under which a member may lose coverage;
6. A description of the grievance and request for hearing procedures;
7. Copayment, coinsurance, and deductible schedules;
8. Information on obtaining health services and on the maintenance of personal and family health; and
9. Information regarding ~~emergency and medically necessary~~ medically necessary emergency transportation offered by ~~the HCG Plan; and~~ an HCG Plan.
10. ~~Other information necessary to use the program.~~

B. Notification of changes in services. HCGA shall prepare and distribute to members a printed member handbook ~~insert~~ endorsement describing any changes, including changes to deductibles, coinsurance, and copayments that HCGA proposes to make in services provided within ~~the HCG Plan's service areas.~~ the HCG network. HCGA shall distribute the ~~insert~~ endorsement to all affected members and dependents at least 14 days before a planned change. HCGA shall provide notification as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-702. ~~Prohibition Against Charges to Members~~ Charges to Members

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

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

the written agreement of the member to accept financial responsibility for the difference.

R9-27-703. Payments by ~~HCG Plans~~ an HCG Plan

~~**A.** A HCG Plan is not responsible for reimbursing a provider if the member requests provision of services, other than emergency medical services, that are excluded under the GSA, have not been authorized by the HCG Plan, or are not the result of a referral to the provider by the HCG Plan or the member's primary care physician.~~

A. Neither HCGA nor an HCG Plan is responsible for reimbursing a provider for services which are:
1. Excluded under the GSA; or
2. In the case of non-emergency services, services not authorized by an HCG Plan or that did not result from a referral.

B. ~~A HCG Plan~~ An HCG Plan shall reimburse a network provider for covered services as specified in the subcontract between the HCG Plan and the provider.

C. If a member receives emergency medical services from a provider other than a network provider, or if ~~the HCG Plan authorizes~~ an HCG Plan authorizes services to be delivered by, or refers a member to~~,~~ a provider other than a network provider, ~~the HCG Plan~~ the HCG Plan shall reimburse the provider for covered services at the lesser of billed charges or an amount negotiated with the provider less any copayment, coinsurance, or deductible as described in the GSA.

D. ~~A HCG Plan~~ An HCG Plan shall adjudicate claims from providers within 60 days of receipt of a clean claim from the provider unless a different time is specified in the subcontract between the HCG Plan and the provider.

R9-27-704. ~~HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members~~ Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members

~~A HCG Plan~~ An HCG Plan shall reimburse a noncontracting hospital for the provision of emergency and ~~subsequent care~~ post-stabilization services to ~~an enrolled member~~ a member in accordance with the terms of the ~~HCG plan's~~ HCG Plan's contract with HCGA and the GSA. Unless the GSA or contract with HCGA states otherwise, ~~a~~ the HCG Plan shall meet the following requirements:

1. Liability to noncontracting hospitals. ~~A HCG Plan~~ An HCG Plan shall reimburse a noncontracting hospital for a member's emergency medical ~~condition~~ services until the member's condition is stabilized and the member is transferable to a contracting hospital or is discharged after the member's condition is stabilized.
2. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a contracting hospital, neither ~~the~~ HCGA nor ~~the HCG Plan is~~ an HCG Plan is liable for any costs incurred after the date of refusal when:
   a. The HCG Plan ~~has~~ consulted with the member and the member ~~continues~~ continued to refuse the transfer; and
   b. The member is provided and signs a written statement of liability on or before the date of consult by which the member indicates the member is aware of the financial consequences of refusing to transfer, or two witnesses sign a statement indicating that the member was provided the statement of liability but refused to sign.