

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:

R9-22-202	Amend
R9-22-1202	Amend

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

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907

Implementing statute: A.R.S. §§ 36-2907, 36-2906

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

Notice of Rulemaking Docket Opening: [to be filled in by SOS editor]

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

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

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 An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Administration is proposing a rulemaking to clarify an issue that has been identified through the administrative hearing process regarding contractor responsibility for covering inpatient hospital services when both medical and behavioral health services are provided during the same hospital stay. The proposed rule will clarify the reimbursement methodology.

The Administration is proposing to clarify through rule, its existing policy that the RBHA is responsible for all inpatient hospital services if the principle diagnosis on the hospital claim is a behavioral health diagnosis. Those claims will be paid in accordance with a per diem fee schedule developed by ADHS and approved by AHCCCS. Hospital claims that do not have a behavioral health diagnosis as the principle diagnosis will be paid by the acute care contractor using the DRG payment methodology. This proposed amendment will benefit hospitals by clarifying to whom claims should be submitted and the amount of reimbursement that the hospital can expect. The Administration intends to initiate and implement this clarification as soon as possible to reduce billing disputes between hospitals and health plans and to reduce unnecessary administrative hearings arising from those disputes.

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

A study was not referenced or relied upon when revising the proposed regulations.

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

Not applicable.

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

The Administration anticipates no economic impact on the implementing agency, contractors, providers, small businesses and consumers because the change is clarifying an existing process that is currently implemented in policy and it is consistent with the current rule regarding reimbursement pursuant to R9-22-712.61(B).

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

Name: Mariaelena Ugarte

Address: AHCCCS

Office of Administrative Legal Services

701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Web site: www.azahcccs.gov

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

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of November 16, 2014. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., January 5, 2015.

Date: January 5, 2015
Time: 2:00 p.m.
Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: January 5, 2015
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
1010 N. Finance Center Dr, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: January 5, 2015
Time: 2:00 p.m.
Location: 2717 N. 4th St. STE 130
Flagstaff, AZ 86004
Nature: Public Hearing

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

No other matters have been prescribed.

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

Not applicable

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

Not applicable

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

No analysis was submitted.

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section

R9-22-202. General Requirements

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

Section

R9-22-1202. ADHS, ~~and~~ Contractor, Administration and CRS Responsibilities

ARTICLE 2. SCOPE OF SERVICES

R9-22-202. General Requirements

A. For the purposes of this Article, the following definitions apply:

1. “Authorization” means written, verbal, or electronic authorization by:
 - a. The Administration for services rendered to a fee-for-service member, or
 - b. The contractor for services rendered to a prepaid capitated member.
2. Use of the phrase “attending physician” applies only to the fee-for-service population.

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor’s network without a referral from a primary care provider.
6. A member may receive physical and behavioral health services as specified in Articles 2 and 12.
7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
8. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.
9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:

- a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously, and
 - c. Personal care items except as specified under R9-22-212.
10. Medical or behavioral health services are not covered services if provided to:
- a. An inmate of a public institution;
 - b. A person who is in residence at an institution for the treatment of tuberculosis; or
 - c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.
- C.** The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F.** A service is not a covered service if provided outside the GSA unless one of the following applies:
- 1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 - 2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family;
 - 3. The contractor authorizes placement in a nursing facility located out of the GSA; or
 - 4. Services are provided during prior period coverage.
- G.** If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

- H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- I.** The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J.** The restrictions, limitations, and exclusions in this Article do not apply to the following:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27, and
 2. A contractor electing to provide noncovered services.
 - a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 - b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
- K.** Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for 100 percent federal financial participation:
1. R9-22-205(A)(8),
 2. R9-22-205(B)(4)(f),
 3. R9-22-206,
 4. R9-22-207,
 5. R9-22-212(C),
 6. R9-22-212(D),
 7. R9-22-212(E)(8),
 8. R9-22-215(C)(2), and
 9. R9-22-215(C)(5).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1202. ADHS, ~~and~~ Contractor, Administration and CRS Responsibilities

- A.** ADHS responsibilities. ADHS is responsible for payment of behavioral health services provided to members, except as specified under subsection (D). ADHS' responsibility for payment of behavioral health services includes claims for inpatient hospital services, which may include physical health services, when the principle diagnosis on the hospital claim is a behavioral health diagnosis. Behavioral health diagnoses are identified as "mental disorders" in the latest ICD code set.
- B.** ADHS/DBHS may contract with a TRBHA for the provision of behavioral health services for American Indian members. American Indian members may receive covered behavioral health services:
1. From an IHS or tribally operated 638 facility,
 2. From a TRBHA, or
 3. From a RBHA.
- C.** Contractor responsibilities. A contractor shall:
1. Refer a member to ~~an~~ a RBHA under the contract terms;
 2. Provide EPSDT developmental and behavioral health screening as specified in R9-22-213; ~~and~~
 3. Coordinate a member's transition of care and medical records; ~~;~~ and
 4. Be responsible for providing inpatient hospital services, which may include behavioral health inpatient hospital services, when the principle diagnosis on the hospital claim is other than a behavioral health diagnosis.
- D.** Administration and CRS responsibilities.
1. The Administration shall be responsible for payment of behavioral health services provided to an ALTCS FFS or an FES member and for behavioral health services provided by IHS and tribally operated 638 facilities. The Administration is also responsible for payment of behavioral health services provided to these members during prior quarter coverage.
 2. CRS shall be responsible for payment of behavioral health services provided to members enrolled with CRS.