TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS – INSURANCE DIVISION

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

R20-6-1902. Definitions

In addition to the definitions provided in A.R.S. § 20-1051, the following terms apply to this Article:

1. "Access" or "accessibility" means the extent to which an enrollee can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.
2. "Adult" means an enrollee in the age group the HCSO has designated for an adult.
3. "Adult PCP" means a primary care provider practicing in any specialty the HCSO designates as adult primary care.
4. "Ancillary provider" means a provider of laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, or speech therapy, home health services, dialysis, and durable medical equipment or medical supplies dispensed by order or prescription of a provider with the appropriate prescribing authority.
5. "Available" or "availability" means the extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.
6. "Chief executive officer" or "CEO" means the person who has the authority and responsibility for the operation of the health care services organization according to applicable legal requirements and policies approved by the governing authority.
7. "Child" means an enrollee in the age group the HCSO has designated for children.
8. "Contracted" means a provider has a current written agreement or an employment arrangement with an HCSO to provide covered services to an enrollee, or a current written agreement or an employment arrangement with a contracted provider to provide covered services to an enrollee.
9. "Covered" or "covered services" means the health care services described as covered benefits in the HCSO's evidence of coverage.
10. "Day" means calendar day unless specified otherwise.
11. "Department" means the Department of Insurance and Financial Institutions.
12. "Director" has the meaning stated at A.R.S. § 20-102.
13. "Effective process" means written policies and procedures that:
    a. Outline the steps that the HCSO implements and consistently follows internally,
    b. The HCSO subjects to internal quality improvement, and
    c. The HCSO communicates to providers when established or changed.
14. "Emergency services" has the meaning stated at A.R.S. § 20-2801(3).
15. "Facility" means an institution that is licensed or authorized to furnish health care services in this state, including general hospitals, special hospitals, residential treatment centers, residential rehabilitation centers, skilled nursing facilities, urgent care centers, and ambulatory surgical treatment centers.

16. “Governing authority” means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the HCSO is vested.
17. “HCSO” means a health care services organization.
18. “High profile” means one of no fewer than four specialties designated by the HCSO, and does not include obstetrics-gynecology. An HCSO may designate a specialty as high profile on the basis of high volume or other basis the HCSO reasonably determines is directly related to providing covered services to a member.
19. “Hospital” means a facility that provides inpatient care, medical services, and continuous nursing services for the diagnosis and treatment of patients.
20. “Inpatient care” means the covered services that an enrollee who is admitted to a hospital receives for at least 24 consecutive hours.
21. “Inpatient emergency care” means covered services that would be emergency services if provided in a licensed hospital emergency facility.
22. “License” means documented authorization issued by the appropriate state of Arizona agency to operate a facility in Arizona, or to practice a health care profession in Arizona.
23. “Medically necessary” has the meaning set forth in the HCSO’s evidence of coverage.
24. “Network” means the group of providers contracted with an HCSO to provide covered services to an enrollee covered under the HCSO’s health benefit plan.
25. “Network exception” means an enrollee receives covered services from a non-contracted provider either:
    a. Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or
    b. For any reason the HCSO determines it is in the enrollee’s best interests to receive care from a non-contracted provider.
26. “Non-contracted” means a provider that does not have a contract with an HCSO to provide services to an enrollee.
27. “Normal business hours” means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state or national holidays.
28. “Outpatient care” means covered services that an enrollee who is not an inpatient receives.
29. “Pediatric primary care provider” means a physician or practitioner practicing in any specialty the HCSO designates as pediatric primary care.
30. “Physician” means a licensed doctor of allopathic, chiropractic, optometric, osteopathic, or podiatric medicine.
31. “Practitioner” means any individual other than a physician who is licensed to furnish health care services, including behavioral health care services, in this state.
32. “Preventive care” means health maintenance care the HCSO provides or arranges to prevent illness and to improve the general health of an enrollee, including:
    a. Immunizations,
    b. Health education,
    c. Health evaluation and follow-up,
    d. Early disease detection,
    e. Screening tests appropriate for a person’s age and gender, and
    f. Periodic health care examinations.
33. “Primary care” means any specialty the HCSO designates as primary care.

34. “Primary care physician” or “PCP” means a physician or practitioner practicing in a specialty the HCSO designates as primary care.
35. “Quality improvement” means an HCSO’s system for assessing and improving the level of performance of key process and outcomes.
36. “Routine care” means covered primary care for an enrollee’s non-urgent, symptomatic condition.
37. “Rural” means a zip code area with fewer than 1,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.
38. “Service area” means any geographic area designated by any HCSO and approved by the Director under A.R.S. § 20-1053(A)(11).
39. “Special hospital” means a hospital that is licensed to provide hospital services within a specific area of medicine, or limits patient admission according to age, gender, type of disease, or medical condition.
40. “Specialty” or “specialty care” means a specific area of medicine practiced by a physician or practitioner who has education, training, or qualifications in that specific area of medicine in addition to the education or qualifications required for the physician’s or practitioner’s license.
41. “Specialty care provider” or “SCP” means a physician or practitioner who has education, training, or qualifications in a specialty, other than primary care, beyond the education or qualifications required for the license.
42. “Suburban area” means any zip code area with 1,000-3,000 persons per square mile, as calculated annually by a population data gathering service designated by the Director.
43. “Telemedicine” has the same meaning as “telehealth” found at A.R.S. § 20-1057(G).
44. “Timely” means services are provided at the time when medically necessary.
45. “Travel expenses” has the meaning set forth in writing by an HCSO.
46. “Urban area” means a zip code with more than 3,000 persons per square mile as calculated annually by a population data gathering service designated by the Director.
47. “Urgent care” means unscheduled services for an enrollee’s condition that requires medical attention not amenable to scheduling in order to avoid a serious risk of harm.

R20-6-1906. Chief Executive Officer

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

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

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

D. The HCSO shall ensure that all HCSO employees and contracted providers are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.

E. The HCSO shall designate a central place of business from which the HCSO shall direct administrative activities.

R20-6-1912. Network Directories

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

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

C. Each HCSO shall make its current network directory available on paper to enrollees or prospective enrollees upon request.

D. Each HCSO that has an online network directory shall:
1. Update the online directory at least monthly and in conformance with A.R.S. § 20-3455;
2. Make the online directory easy to use and user friendly; and
3. Explain, in the online directory, how an enrollee or prospective enrollee can request a paper directory.