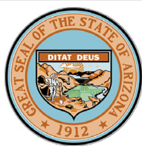

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Arizona Administrative REGISTER

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Vol. 27, Issue 7 **~ Administrative Register Contents ~** **February 12, 2021**

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From the Publisher

ABOUT THIS PUBLICATION

The authenticated pdf of the *Administrative Register* (A.A.R.) posted on the Arizona Secretary of State's website is the official published version for rulemaking activity in the state of Arizona.

Rulemaking is defined in Arizona Revised Statutes known as the Arizona Administrative Procedure Act (APA), A.R.S. Title 41, Chapter 6, Articles 1 through 10.

The *Register* is cited by volume and page number. Volumes are published by calendar year with issues published weekly. Page numbering continues in each weekly issue.

In addition, the *Register* contains notices of rules terminated by the agency and rules that have expired.

ABOUT RULES

Rules can be: made (all new text); amended (rules on file, changing text); repealed (removing text); or renumbered (moving rules to a different Section number). Rulemaking activity published in the *Register* includes: proposed, final, emergency, expedited, and exempt rules as defined in the APA, and other state statutes.

New rules in this publication (whether proposed or made) are denoted with underlining; repealed text is stricken.

WHERE IS A "CLEAN" COPY OF THE FINAL OR EXEMPT RULE PUBLISHED IN THE *REGISTER*?

The *Arizona Administrative Code* (A.A.C) contains the codified text of rules. The A.A.C. contains rules promulgated and filed by state agencies that have been approved by the Attorney General or the Governor's Regulatory Review Council. The *Code* also contains rules exempt from the rulemaking process.

The authenticated pdf of *Code* chapters posted on the Arizona Secretary of State's website are the official published version of rules in the A.A.C. The *Code* is posted online for free.

LEGAL CITATIONS AND FILING NUMBERS

On the cover: Each agency is assigned a Chapter in the *Arizona Administrative Code* under a specific Title. Titles represent broad subject areas. The Title number is listed first; with the acronym A.A.C., which stands for the *Arizona Administrative Code*; following the Chapter number and Agency name, then program name. For example, the Secretary of State has rules on rulemaking in Title 1, Chapter 1 of the *Arizona Administrative Code*. The citation for this chapter is 1 A.A.C. 1, Secretary of State, Rules and Rulemaking

Every document filed in the office is assigned a file number. This number, enclosed in brackets, is located at the top right of the published documents in the *Register*. The original filed document is available for 10 cents a page.

Arizona Administrative REGISTER

Vol. 27 **Issue 7**

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ADMINISTRATIVE REGISTER
This publication is available online for free at www.azsos.gov.

ADMINISTRATIVE CODE
A price list for the *Arizona Administrative Code* is available online. You may also request a paper price list by mail. To purchase a paper Chapter, contact us at (602) 364-3223.

PUBLICATION DEADLINES
Publication dates are published in the back of the *Register*. These dates include file submittal dates with a three-week turnaround from filing to published document.

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The Office of the Secretary of State is an equal opportunity employer.

Participate in the Process

Look for the Agency Notice

Review (inspect) notices published in the *Arizona Administrative Register.* Many agencies maintain stakeholder lists and would be glad to inform you when they proposed changes to rules. Check an agency's website and its newsletters for news about notices and meetings.

Feel like a change should be made to a rule and an agency has not proposed changes? You can petition an agency to make, amend, or repeal a rule. The agency must respond to the petition. (See A.R.S. § 41-1033)

Attend a public hearing/meeting

Attend a public meeting that is being conducted by the agency on a Notice of Proposed Rulemaking. Public meetings may be listed in the Preamble of a Notice of Proposed Rulemaking or they may be published separately in the *Register*. Be prepared to speak, attend the meeting, and make an oral comment.

An agency may not have a public meeting scheduled on the Notice of Proposed Rulemaking. If not, you may request that the agency schedule a proceeding. This request must be put in writing within 30 days after the published Notice of Proposed Rulemaking.

Write the agency

Put your comments in writing to the agency. In order for the agency to consider your comments, the agency must receive them by the close of record. The comment must be received within the 30-day comment timeframe following the *Register* publication of the Notice of Proposed Rulemaking.

You can also submit to the Governor's Regulatory Review Council written comments that are relevant to the Council's power to review a given rule (A.R.S. § 41-1052). The Council reviews the rule at the end of the rulemaking process and before the rules are filed with the Secretary of State.

Arizona Regular Rulemaking Process

START HERE
APA, statute or ballot proposition is passed. It gives an agency authority to make rules.
It may give an agency an exemption to the process or portions thereof.

→ Agency opens a docket.
Agency files a Notice of Rulemaking Docket Opening; it is published in the *Register.* Often an agency will file the docket with the proposed rulemaking.

→ Agency decides not to act and closes docket.
The agency may let the docket lapse by not filing a Notice of Proposed rulemaking within one year.

↓ Agency drafts proposed rule and Economic Impact Statement (EIS); informal public review/comment.

↓ Agency files Notice of Proposed Rulemaking.
Notice is published in the *Register*.
Notice of meetings may be published in *Register* or included in Preamble of Proposed Rulemaking.
Agency opens comment period.

→ Agency decides not to proceed and does not file final rule with G.R.R.C. within one year after proposed rule is published. A.R.S. § 41-1021(A)(4).
Agency decides not to proceed and files Notice of Termination of Rulemaking for publication in *Register*. A.R.S. § 41-1021(A)(2).

↓ Oral proceeding and close of record. Comment period must last at least 30 days after publication of notice. Oral proceeding (hearing) is held no sooner than 30 days after publication of notice of hearing

Substantial change?

← Agency files Notice of Supplemental Proposed Rulemaking. Notice published in *Register.*

→ Agency decides not to proceed; files Notice of Termination of Rulemaking. May open a new Docket.

If no change then

↓ Rule must be submitted for review or terminated within 120 days after the close of the record.

↓ A final rulemaking package is submitted to G.R.R.C. or A.G. for review. Contains final preamble, rules, and Economic Impact Statement.

↓ G.R.R.C. has 90 days to review and approve or return the rule package, in whole or in part; A.G. has 60 days.

↓ After approval by G.R.R.C. or A.G., the rule becomes effective 60 days after filing with the Secretary of State (unless otherwise indicated).

Final rule is published in the *Register* and the quarterly *Code* Supplement.

Definitions

***Arizona Administrative Code* (A.A.C.):** Official rules codified and published by the Secretary of State's Office. Available online at www.azsos.gov.

***Arizona Administrative Register* (A.A.R.):** The official publication that includes filed documents pertaining to Arizona rulemaking. Available online at www.azsos.gov.

Administrative Procedure Act (APA): A.R.S. Title 41, Chapter 6, Articles 1 through 10. Available online at www.azleg.gov.

Arizona Revised Statutes (A.R.S.): The statutes are made by the Arizona State Legislature during a legislative session. They are complied by Legislative Council, with the official publication codified by Thomson West. Citations to statutes include Titles which represent broad subject areas. The Title number is followed by the Section number. For example, A.R.S. § 41-1001 is the definitions Section of Title 41 of the Arizona Administrative Procedures Act. The "§" symbol simply means "section." Available online at www.azleg.gov.

Chapter: A division in the codification of the *Code* designating a state agency or, for a large agency, a major program.

Close of Record: The close of the public record for a proposed rulemaking is the date an agency chooses as the last date it will accept public comments, either written or oral.

Code of Federal Regulations (CFR): The *Code of Federal Regulations* is a codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government.

Docket: A public file for each rulemaking containing materials related to the proceedings of that rulemaking. The docket file is established and maintained by an agency from the time it begins to consider making a rule until the rulemaking is finished. The agency provides public notice of the docket by filing a Notice of Rulemaking Docket Opening with the Office for publication in the *Register*.

Economic, Small Business, and Consumer Impact Statement (EIS): The EIS identifies the impact of the rule on private and public employment, on small businesses, and on consumers. It includes an analysis of the probable costs and benefits of the rule. An agency includes a brief summary of the EIS in its preamble. The EIS is not published in the *Register* but is available from the agency promulgating the rule. The EIS is also filed with the rulemaking package.

Governor's Regulatory Review (G.R.R.C.): Reviews and approves rules to ensure that they are necessary and to avoid unnecessary duplication and adverse impact on the public. G.R.R.C. also assesses whether the rules are clear, concise, understandable, legal, consistent with legislative intent, and whether the benefits of a rule outweigh the cost.

Incorporated by Reference: An agency may incorporate by reference standards or other publications. These standards are available from the state agency with references on where to order the standard or review it online.

Federal Register (FR): The *Federal Register* is a legal newspaper published every business day by the National Archives and Records Administration (NARA). It contains federal agency regulations; proposed rules and notices; and executive orders, proclamations, and other presidential documents.

Session Laws or "Laws": When an agency references a law that has not yet been codified into the Arizona Revised Statutes, use the word "Laws" is followed by the year the law was passed by the Legislature, followed by the Chapter number using the abbreviation "Ch.", and the specific Section number using the Section symbol (§). For example, Laws 1995, Ch. 6, § 2. Session laws are available at www.azleg.gov.

United States Code (U.S.C.): The Code is a consolidation and codification by subject matter of the general and permanent laws of the United States. The Code does not include regulations issued by executive branch agencies, decisions of the federal courts, treaties, or laws enacted by state or local governments.

Acronyms

A.A.C. – *Arizona Administrative Code*

A.A.R. – Arizona Administrative Register

APA – Administrative Procedure Act

A.R.S. – Arizona Revised Statutes

CFR – *Code of Federal Regulations*

EIS – Economic, Small Business, and Consumer Impact Statement

FR – *Federal Register*

G.R.R.C. – Governor's Regulatory Review Council

U.S.C. – *United States Code*

About Preambles

The Preamble is the part of a rulemaking package that contains information about the rulemaking and provides agency justification and regulatory intent.

It includes reference to the specific statutes authorizing the agency to make the rule, an explanation of the rule, reasons for proposing the rule, and the preliminary Economic Impact Statement.

The information in the Preamble differs between rulemaking notices used and the stage of the rulemaking.

NOTICES OF PROPOSED RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Proposed Rulemakings.

A proposed rulemaking is filed by an agency upon completion and submittal of a Notice of Rulemaking Docket Opening. Often these two documents are filed at the same time and published in the same *Register* issue.

When an agency files a Notice of Proposed Rulemaking under the Administrative Procedure Act (APA), the notice is published in the *Register* within three weeks of filing. See the publication schedule in the back of each issue of the *Register* for more information.

Under the APA, 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).

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the proposed rules should be addressed to the agency that promulgated the rules. Refer to item #4 below to contact the person charged with the rulemaking and item #10 for the close of record and information related to public hearings and oral comments.

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

INSURANCE DIVISION

[R21-10]

PREAMBLE

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

Article, Part or Section Affected (as applicable)	Rulemaking Action
Article 15	New Article
R20-6-1501	New Section
R20-6-1502	New Section
R20-6-1503	New Section
R20-6-1504	New Section
R20-6-1505	New Section
R20-6-1506	New Section
Exhibit A	New Exhibit
Exhibit B	New Exhibit
Exhibit C	New Exhibit
Exhibit D	New Exhibit
Exhibit E	New Exhibit
Exhibit F	New Exhibit
Exhibit G	New Exhibit
Exhibit H	New Exhibit
Exhibit I	New Exhibit
Exhibit J	New Exhibit
Exhibit K	New Exhibit
Exhibit L	New Exhibit
Exhibit M	New Exhibit
Exhibit N	New Exhibit

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. § 20-143

Implementing statute: Laws 2020, Chap. 4, Sec. 8. (SB1523)

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: 26 A.A.R. 1882, September 11, 2020.

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

Name: Mary E. Kosinski

Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, AZ 85007-2630

Telephone: (602) 364-3476

E-mail: mary.kosinski@difi.az.gov

Website: https://difi.az.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:

In 2020, the Arizona Legislature enacted the Arizona Mental Health Parity Act (also known as "Jake's Law") at A.R.S. §§ 20-3501 through 20-3505 to implement the provisions of the federal Mental Health Parity and Addiction Equity Act ("MHPAEA" 42 U.S.C. 300gg-26 and implementing regulations) on the state level. It also charged the Department of Insurance and Financial Institutions ("Department"), Insurance Division ("Division") to: "adopt by rule both of the following: 1. Forms or worksheets that health care insurers must use to prepare the reports required by section 20-3502 . . . and 2. Standards to determine compliance with the mental health parity and addiction equity act." Laws 2020, Chap. 4, Sec. 8. (SB1523).

MHPAEA generally establishes that health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits may not, among other things, impose less favorable benefit limitations on MH/SUD benefits than on medical/surgical benefits. State insurance authorities, the U.S. Department of Health and Human Services, and the U.S. Department of Labor (U.S. DOL) have jurisdiction over applicable individual and group health insurance policies. MHPAEA regulations establish standards related to insurers' application of financial requirements (e.g., deductibles and co-payments), quantitative treatment limitations (e.g., visit limits), and nonquantitative treatment limitations (e.g., step therapy, prior authorization). Health insurers cannot apply financial requirements (FRs) or quantitative treatment limitations (QTLs) to MH/SUD policy benefits that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. Nor can health insurers impose nonquantitative treatment limitations (NQTLs) with respect to MH/SUD benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefit classifications are comparable to those used with medical surgical/benefits classifications.

This rulemaking is intended to fulfill the Legislature's charge to create forms and worksheets that health care insurers must use to prepare the reports required by A.R.S. § 20-3502 and establish standards to determine compliance with MHPAEA.

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:

The Division did not review and does not propose to rely on any study relevant to this rulemaking.

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:

The rulemaking does not diminish a previous grant of authority granted to the Division.

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

Pursuant to A.R.S. § 41-1055(A):

- The conduct the rulemaking is designed to change is the practice of health care insurers that provide mental health or substance use disorder ("MH/SUD") benefits to provide those benefits on parity with the provision of medical and surgical ("Med/Surg") benefits. This means that limitations insurers impose on MH/SUD benefits can be no more stringent or less favorable than the limitations the insurer imposes on Med/Surg benefits.
- The failure of a health care insurer to provide MH/SUD benefits on parity with Med/Surg benefits may result in having an insured unable to obtain MH/SUD medical care because the limitations imposed on those benefits is more stringent or less favorable than imposed on other types of benefits.
- It is not presumed that the health care insurers in Arizona are non-compliant with the parity requirements of the Arizona Mental Health Parity Act (A.R.S. §§ 20-3501 through 20-3505). However, the reporting requirements of the rulemaking will ensure that health care insurers remain in compliance with the Act.
- The costs incurred by health insurers are not expected to impact revenues or payroll expenditures. Instead, the costs incurred are compliance costs driven by the reporting requirements imposed by the proposed rulemaking. Many insurers are already familiar with MHPAEA and have been complying through federal regulations imposed on portions of their business. These already incurred costs are not expected to change appreciably under the proposed rulemaking. Additional costs, however, may arise in order to comply with the additional reporting requirements imposed by the proposed rulemaking. But, these costs are not anticipated to impact revenues or payroll expenditures.
- Groups participating in the listening sessions allowed under the bill generally requested that the Division demonstrate that it has selected an alternative that imposes the least burden and costs to persons regulated by the rule under A.R.S. § 41-1052 although they did not enumerate any anticipated costs. Further, these groups claimed that some of the standards chosen by the Division go beyond the authority granted to the Division in the session law (Laws 2020, Chap. 4, Sec. 8. (SB1523).
- The employee listed in Item 9 may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement.

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

Name: Mary E. Kosinski

Address: Department of Insurance and Financial Institutions
100 N. 15th Ave., Suite 261
Phoenix, AZ 85007-2630

Telephone: (602) 364-3476

E-mail: mary.kosinski@difi.az.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:

The Division will conduct a public hearing virtually on **March 15, 2021, from 10:00 a.m. to 2:00 p.m. (MT).** The meeting agenda and instructions for attending the meeting will be posted on the Department's website prior to the hearing (https://difi.az.gov).

Public comments may be submitted to the following e-mail address: public_comments@difi.az.gov until **March 14, 2021, at 11:59 p.m. (MT)**.

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 prescribed by statute are applicable to the Division or to any specific rule or class of rules.

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:

The rule does not require a permit and does not use a general permit. Instead, the rule is designed to provide guidance to health care insurers on the reporting requirements of A.R.S. § 20-3502 and the standards to determine compliance with MHPAEA.

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:

The Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 U.S.C. 300gg-26 and implementing regulations) is applicable to the subject of the rule. The rule is not more stringent than the federal law. Instead, the rule requires health care insurers to complete reports that flag non-compliance with the provisions of MHPAEA.

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 formal analysis has been submitted to the Division that compares the rule's impact of the competitiveness of business in this state to the impact of business in other states.

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

The rule points health care insurers to other information sources that may be helpful for compliance with MHPAEA but does not incorporate any reference material into the rule as specified at A.R.S. § 41-1028.

13. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS INSURANCE DIVISION

ARTICLE 15. ~~RESERVED~~MENTAL HEALTH PARITY

Section

R20-6-1501. Definitions
R20-6-1502. Additional Guidance
R20-6-1503. Medical Necessity Criteria and NQTL Reporting
R20-6-1504. FR and QTL Reporting
R20-6-1505. HEDIS Reporting
R20-6-1506. NQTL Compliance Indicators Reporting
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ARTICLE 15. ~~RESERVED~~MENTAL HEALTH PARITY

R20-6-1501. Definitions

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

"Arizona Mental Health Parity Act" means the statutes found at A.R.S. §§ 20-3501 through 20-3505.

"Coverage unit" means the way in which a health plan (or health insurance coverage) groups individuals for purposes of determining benefits, or premiums, or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Division" means the Division of Insurance of the Department.

"Financial requirement (FR)" means deductibles, copayments, coinsurance, or out-of-pocket maximums. FRs do not include aggregate lifetime or annual dollar limits.

"Health care insurer" has the meaning prescribed in A.R.S. § 20-3501(2).

"Health plan" has the meaning prescribed in A.R.S. § 20-3501(3).

"HEDIS" means the Healthcare Effectiveness Data and Information Set published by the National Committee for Quality Assurance (NCQA).

"HHS MHPAEA tool" means the Mental Health Parity tool offered by the U.S. Department of Health and Human Services.

"Inpatient, in-network benefits" are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan.

"Inpatient, out-of-network benefits" are benefits furnished on an inpatient basis by providers without a contract under a health plan or for a health plan that has no network of providers.

"Medical/surgical (Med/Surg) benefits" means benefits with respect to items or services for medical conditions or surgical procedures as defined under the terms of the health plan or health insurance coverage and in accordance with federal and state law and consistent with generally recognized independent standards of current medical practice. Med/Surg benefits does not include mental health (MH) or substance use disorder (SUD) benefits.

"Mental (MH) health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health plan or health insurance coverage and in accordance with applicable federal and state law and consistent with generally recognized independent standards of current medical practice. MH benefits include intermediate benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment), medication assisted treatment (MAT) and treatment for eating disorders.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

"Nonquantitative treatment limitation (NQTL)" is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigative as identified under 45 C.F.R. 146.136(c)(4)(ii)(A); formulary design for prescription drugs as identified under 45 C.F.R. 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 C.F.R. 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified under 45 C.F.R. 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45 C.F.R. 146.136(c)(4)(ii)(E); refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first policies" or "step therapy protocols") as identified under 45 C.F.R. 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 C.F.R. 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 C.F.R. 146.136(c)(4)(ii)(H).

"Outpatient, in-network benefits" are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan.

"Outpatient, out-of-network benefits" are benefits furnished on an outpatient basis and outside any network of providers established or recognized under a health plan or under a health plan that has no network of providers.

"Predominant test" means that if a type of FR or QTL applies to substantially all of the Med/Surg benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than 1/2 of the Med/Surg benefits in that classification subject to the FR or QTL. If no single level can be determined, the health plan (or health insurance issuer) may combine levels until the combination of levels applies to more than 1/2 of Med/Surg benefits subject to the FR or QTL in the classification. The least restrictive level within the combination is considered the predominant level of that type of classification. For this purpose, a health plan may combine the most restrictive levels first with each less restrictive level added to the combination until the combination applies to more than 1/2 of the benefits subject to the FR or QTL.

"Quantitative treatment limitation (QTL)" is a limitation on the scope or duration of a benefit that can be expressed numerically that includes day or visit limits such as "50 outpatient visits per year." QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

"Substance use disorder (SUD) benefits" means benefits with respect to items or services for substance use disorders as defined under the terms of the health plan or health insurance coverage and in accordance with applicable federal and state law and consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include intermediate benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment), medication assisted treatment (MAT), and treatment for eating disorders.

"Substantially all test" means that a FR or QTL applies to at least 2/3 of all Med/Surg benefits in a classification of benefits for a coverage unit. (For this purpose, benefits expressed as subject to a zero level of a type of FR are treated as not subject to that type of FR. In addition, benefits expressed as subject to an unlimited QTL are treated as not subject to that type of QTL.) If a

type of FR or QTL does not apply to at least 2/3 of all Med/Surg benefits in a classification, then that type of FR or QTL cannot be applied to MH or SUD benefits in that classification.

R20-6-1502. Additional Guidance

Additional guidance regarding MHPAEA include, but are not limited to the following:

A. 42 U.S.C. 300gg-26;
B. 45 CFR 146.136;
C. U.S. Department of Labor at www.dol.gov/agencies/ebsa and by using the Department of Labor Self-Compliance Tool;
D. The Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at www.cms.gov/CCIIO and the HHS MHPAEA tool; and
E. The National Association of Insurance Commissioners (NAIC) at www.naic.org.

R20-6-1503. Medical Necessity Criteria and NQTL Reporting

A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Division.
B. Health plans subject to reporting. A health care insurer shall submit a separate report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (B)(4) of this Section. If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a report for each variation.
    1. The health plan offers either MH or SUD benefits in addition to Med/Surg benefits.
    2. The health plan offers either MH or SUD benefits in any one of the following classifications:
        a. Inpatient, in-network;
        b. Inpatient, out-of-network;
        c. Outpatient, in-network;
        d. Outpatient, out-of-network;
        e. Emergency care; or
        f. Prescription drugs.
    3. The health plan is offered on a group (large or small) or individual basis.
    4. The health plan has not received and notified the Division of an increased cost exemption pursuant to 45 C.F.R. 146.136(g).
C. Health plans exempt from reporting. A health plan that meets the criteria of Subsection (B) above is exempt from reporting under this Article if it is one of the following types of health plans:
    1. A small group grandfathered health plan; or
    2. A health plan that meets the definition of excepted benefit provided in 45 C.F.R. 146.145(b) or 45 C.F.R. 148.220.
D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the insurer must file a separate report for each variation.
E. Triennial Reports.
    1. Existing health care insurers. Beginning on March 15, 2022 and every third year thereafter, a health care insurer issuing health plans and collecting premium in Arizona as of January 1, 2022 shall file a triennial report with the Division for each health plan subject to reporting.
    2. Entering or re-entering health care insurers. On or before March 15 of the second year an entering or re-entering health care insurer issues health plans and collects premiums in Arizona, a health care insurer shall file an original triennial report with the Division for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1) of this Section.
    3. Due date for triennial reports. Triennial reports are due on or before March 15 of each reporting year.
    4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Division under A.R.S. § 20-3502(B) that provides the required information in Exhibits A and B, and Section R20-6-1506.
    5. Subsequent triennial reports.
        a. A health care insurer must file an updated triennial report, including the information required in Exhibits A and B, and Section R20-6-1506, unless the insurer can attest that it has made no changes since the previously filed triennial report.
        b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Division for each health plan subject to reporting:
            i. An updated triennial report, including the information required in Exhibits A and B, and Section R20-6-1506; or
            ii. The last triennial report filed with the Division and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.
F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), on or before March 15 of each intervening year between the filing of a triennial report, a health care insurer shall file:
    1. A report that summarizes any changes made to its medical necessity criteria and NQTLs;
    2. A written attestation that the insurer is in compliance with MHPAEA; and
    3. If requested by the Division, the additional data required in Sections R20-6-1505 and R20-6-1506.
G. Additional information. At any time after an insurer files a report under this Section, the Division may request additional information, including an updated triennial or annual report, by contacting the insurer and making the request in writing. The insurer shall provide contact information to the Division when it files any of the reports required by this Section. The Division may set a deadline for an insurer to respond to its request.

R20-6-1504. FR and QTL Reporting

A. Method of reporting. A health care insurer that issues health plans in Arizona and is not exempt from the form filing requirement shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Division.

B. Division's authority to require additional data. In addition to the forms filed by a health insurer, the Division may require a health insurer to submit additional data relating to its methods for meeting the MHPAEA FR and QTL standards. The Division may utilize the HHS MHPAEA tool and may request samples of a health insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.

C. Separate consolidated report for large group health plans. The Division may require a health insurer that issues large group health plans to file a report that demonstrates compliance with the substantially all and predominant tests within each classification of benefits for health plans with similar benefit structures.

D. Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as follows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.

E. Special rules for FRs and QTLs.

1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has 2 tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network classifications are divided into 2 subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.
2. Outpatient Classifications. The sub-classification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into 2 subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.

F. The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are:

1. Office visits (such as physician visits); and
2. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

R20-6-1505. HEDIS Reporting

Health insurers subject to reporting under Section R20-6-1503 will submit the requested HEDIS measures identified in Exhibit B to the Division unless collection of any measure has been discontinued by the NCQA.

R20-6-1506. NQTL Compliance Indicators Reporting

A. Authority. Pursuant to A.R.S. § 20-3502(B)(3) and 45 C.F.R. 146.136(c)(4)(i), a health plan may not impose a NQTL with respect to MH and SUD benefits in any classification unless, under the terms of the health plan as written and in operation, any process, strategy, evidentiary standard or other factor used in applying the NQTL to MH and SUD benefits in the classification are comparable to, and are applied no more stringently than, any process, strategy, evidentiary standard or other factor used in applying the limit with respect to Med/Surg benefits in the classification. Further, if a health plan or issuer provides MH or SUD benefits in any classification described in the MHPAEA final regulation, MH or SUD benefits must be provided in every classification in which Med/Surg benefits are provided. See, 45 CFR 146.136(c)(2)(ii)(A). To demonstrate compliance with MHPAEA NQTL parity requirements, an insurer subject to reporting under Section R20-6-1503 shall submit additional reports to the Division pursuant to A.R.S. §§ 20-3502(A), (B)(3), (F), and 45 C.F.R. 146.136(c)(4)(ii).

B. Compliance indicators. Compliance indicators, as set forth in this Section, are used by the Division to evaluate MHPAEA compliance comprehensively. Any report submitted pursuant to this Section that triggers submitting additional analysis and data to the Division does not establish a per se MHPAEA violation.

C. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the insurer must file a separate report for each variation.

D. Health plans exempt from reporting. A health care insurer that offers health plans that meet the criteria of Section R20-6-1503(B) is exempt from reporting under this Section if it insures 25 lives or less across all health plans which are otherwise subject to reporting.

E. Reporting schedule. The reports required by this Section shall be submitted to the Division with the insurer's triennial report required under subsection R20-6-1503(E) and, if requested by the Division, with its annual report required under subsection R20-6-1503(F).

F. Compliance indicators for medical management standards.

1. To demonstrate parity compliance with medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative as identified under 45 C.F.R. 146.136(c)(4)(ii)(A), a health plan shall submit Exhibits I, J, K and N to the Division.

2. Prior authorization denial rate for which no claim was subsequently submitted. As reported in Exhibit I, if the prior authorization denial rate for which no claim was subsequently submitted for any type of MH/SUD services (reported separately for prior authorization requests for inpatient facility stays, outpatient facility visits, and office visits and reported separately for prior authorization denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:
   a. A description of how medical management standards for MH/SUD benefits result in higher denial rates than for requests for Med/Surg benefits within the same category;
   b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist providers in their submission of complete requests for medically necessary services; and
   c. An analysis of any other factors that may result in a disproportionate percentage of denials of prior authorization requests for MH/SUD benefits compared to Med/Surg benefits within each category.
3. Claim denial rate for medically necessary services. As reported in Exhibit J, if the claim denial rate for MH/SUD claims (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported separately for claim denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg claims by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:
   a. A description of how medical management standards for MH/SUD benefits result in higher claim denial rates than for requests for Med/Surg benefits within the same category;
   b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist in the submission of complete claims for medically necessary services; and
   c. A listing of any other factors which may result in a disproportionate percentage of denials of claims for MH/SUD benefits compared to Med/Surg benefits within each category.
4. Approval of only lower level of care services. As reported in Exhibit K, if the rate at which an insurer approves services only for a lower level of care for MH/SUD benefits (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported separately for benefit reductions due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same lower level of care approval rate for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:
   a. A description of how medical management standards for MH/SUD benefits result in higher rates of approval only for lower level of care than for requests for Med/Surg benefits within the same category;
   b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist in the submission of complete requests for medically necessary services at an appropriate level of care; and
   c. A listing of any other factors which may result in a disproportionate percentage of approval only for lower level of care for MH/SUD benefits compared to Med/Surg benefits within each category.

G. Compliance indicators for formulary design. To demonstrate parity compliance with formulary design for prescription drugs under 45 C.F.R. 146.136(c)(4)(ii)(B), a health plan shall submit Exhibit H to the Division.

H. Compliance indicators for network tier design.
1. To demonstrate parity compliance with network tier design under 45 C.F.R. 146.136(c)(4)(ii)(C), a health plan with multiple network tiers (such as preferred providers and participating providers) shall submit Exhibit G to the Division.
2. If the percentage of Med/Surg specialty care providers placed in the lowest network tier exceeds the percentage of MH/SUD providers placed in the lowest network tier by more than a factor of two to one, the insurer shall submit additional information to the Division that includes:
   a. An analysis of the relative cost to the insurer for Med/Surg providers compared to MH/SUD providers for services provided in the lowest network tier and in any other network tier; and
   b. Any other factors the insurer uses in determining how providers are placed into tiers.

I. Compliance indicators for provider admission standards.
1. To demonstrate parity compliance with provider admission standards to participate in a network (including reimbursement rates) under 45 C.F.R. 146.136(c)(4)(ii)(D), a health plan shall submit Exhibits C, D, E, F and L to the Division.
2. Ratio of allowed claims. As reported in Exhibit D, if the ratio of allowed claims for MH/SUD out-of-network benefits to allowed claims for Med/Surg benefits received from a specialist exceeds a factor of three to one, the insurer must provide documentation of the corrective actions it will implement to improve the ratio.
3. Percentage of providers accepting new patients. As reported in Exhibit E, if the total percentage of providers accepting new patients for any type of MH/SUD provider type listed in Exhibit E is less than half of the percentage of Med/Surg specialist providers accepting new patients, the insurer shall report corrective data to the Division that includes:
   a. The results of a root cause analysis identifying the reason(s) for the limited number of such providers accepting new patients, which may include documenting that there is a provider shortage for providers of that type; and
   b. The strategies and steps the insurer will employ to increase the number of contracted MH/SUD providers of that type(s) accepting new patients.
4. No in-network claims for outpatient services. As reported in Exhibit F, if the percentage of psychiatrists, child psychiatrists, psychologists, licensed independent clinical social workers, or other MD/SUD licensed professionals who file no in-network claims for outpatient services exceeds the percentage of Med/Surg specialist providers who file no in-network claims for outpatient services, the insurer shall report corrective data to the Division that includes:
   a. The results of a root cause analysis identifying the reason or reasons for the limited number of such providers filing outpatient claims; and

b. The strategies and steps the insurer will employ to ensure that such MH/SUD providers of that type(s) are actively utilized in the network.

J. Compliance indicators for determining charges.

1. To demonstrate parity compliance of health plan methods for determining usual, customary and reasonable charges under 45 C.F.R. 146.136(c)(4)(ii)(E), a health plan shall submit Exhibits C, D, E, F, L and M to the Division and any additional reports generated under Exhibits D, E, and F.
2. Credentialing timeframes. As reported in Exhibit M, if the average time an insurer takes to conclude the process of credentialing and loading an applicant's information into its billing system for any type of MH/SUD provider exceeds the average time an insurer takes to complete the same activities for Med/Surg providers, the insurer shall submit an analysis of the reasons for delay, including provider education, credentialing resources, internal insurer timelines for a response, or any other factor that may result in a disparity between MH/SUD provider credentialing and Med/Surg provider credentialing.

K. Compliance indicators for restrictions on scope or duration of benefits. To demonstrate parity compliance of health plan restrictions that limit the scope or duration of benefits for services provided under the health plan or coverage based on geographic location, facility type, provider specialty, or other criteria under 45 C.F.R. 146.136(c)(4)(ii)(H), a health plan shall submit Exhibits C, D, E and F and any additional reports generated under Exhibits D, E, and F.

L. Duplication of submissions not required. If a health plan is required to submit an exhibit or additional reports under more than one compliance indicator listed at subsections F through K above, a health plan complies with the reporting requirement if it submits one copy of the requested exhibit or additional report to the Division. For example, a health plan that submits Exhibit C to the Division, complies with the portion of subsections I, J, and K requiring the submission of Exhibit C. The health plan is still required to submit all the exhibits or additional reports listed in each subsection.

Exhibit A

Medical Necessity Criteria and NQTL Reports

Instructions

Report information related to the process used to develop or select, and the application of, medical necessity criteria and NQTLs for Med/Surg benefits and MH and SUD benefits. Submit a response for each fully insured, major medical health plan subject to reporting under Section R20-6-1503(B). Please submit the information in a word-searchable PDF file which is organized and identified by the numbered sections that appear below.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

Section A. Med/Surg Benefits

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

A.1. Processes and Strategies Utilized For Developing Medical Necessity Criteria

[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for Med/Surg benefits.]

A.2. Evidentiary Standards Utilized For Developing Medical Necessity Criteria

[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for Med/Surg benefits.]

A.3. Other Factors Utilized For Developing Medical Necessity Criteria

[Describe and itemize any other factors which are utilized for developing medical necessity criteria for Med/Surg benefits.]

A.4. Identify all NQTLs

[Identify all nonquantitative treatment limits that are applied to Med/Surg benefits within each classification of benefits.]

A.5. Retrospective Review Standards

[Describe any retrospective review standards for medical necessity standards for Med/Surg benefits.]

A.6. Use of Treatment Plans

[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for Med/Surg benefits.]

A.7. Use of Fail-First or Step Therapy Protocols

[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered Med/Surg benefits.]

A.8. Concurrent Review Requirements

[Describe how factors for concurrent review requirements for Med/Surg benefits are determined.]

A.9. Requirements for Improvement

[Furnish a list of all Med/Surg benefits which make approval contingent upon improvement within a specific number of days.]

A.10. Other Limitations on Obtaining Covered Benefits

[Furnish a list of any other limitations imposed on obtaining Med/Surg benefits covered by the health benefit plan.]

Section B. MH Benefits

B.1. Processes and Strategies Utilized For Developing Medical Necessity Criteria

[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for MH benefits.]

B.2. Evidentiary Standards Utilized for Developing Medical Necessity Criteria

[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for MH benefits.]

B.3. Other Factors Utilized for Developing Medical Necessity Criteria

[Describe and itemize any other factors which are utilized for developing medical necessity criteria for MH benefits.]

B.4. Identify all NQTLs

[Identify all nonquantitative treatment limits that are applied to MH benefits within each classification of benefits.]

B.5. Retrospective Review Standards

[Describe any retrospective review standards for medical necessity standards for MH benefits.]

B.6. Use of Treatment Plans

[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for MH benefits.]

B.7. Use of Fail-First or Step Therapy Protocols

[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered MH benefits.]

B.8. Concurrent Review Requirements

[Describe how factors for concurrent review requirements for MH are determined.]

B.9. Requirements for Improvement

[Furnish a list of all MH benefits which make approval contingent upon improvement within a specific number of days.]

B.10. Other Limitations on Obtaining Covered Benefits

[Furnish a list of any other limitations imposed on obtaining MH benefits covered by the health benefit plan.]

B.11. Comparison of NQTLs Applied to MH and Med/Surg Benefits

[Furnish a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to MH benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

B.12. Program of Auditing and Monitoring For Compliance

[Furnish a description of the program for auditing and monitoring the application of medical necessity criteria and other medical management standards and nonquantitative treatment limits to MH benefits to ensure that they are not applied more stringently than those criteria or standards applied to Med/Surg benefits in the same classification.]

Section C. SUD Benefits

C.1. Processes and Strategies Utilized for Developing Medical Necessity Criteria

[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for SUD benefits.]

C.2. Evidentiary Standards Utilized for Developing Medical Necessity Criteria

[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for SUD benefits.]

C.3. Other Factors Utilized for Developing Medical Necessity Criteria

[Describe and itemize any other factors which are utilized for developing medical necessity criteria for SUD benefits.]

C.4. Identify all NQTLs

[Identify all nonquantitative treatment limits that are applied to SUD benefits within each classification of benefits.]

C.5. Retrospective Review Standards

[Describe any retrospective review standards for medical necessity standards for SUD benefits.]

C.6. Use of Treatment Plans

[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for SUD benefits.]

C.7. Use of Fail-First or Step Therapy Protocols

[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered SUD benefits.]

C.8. Concurrent Review Requirements

[Describe how factors for concurrent review requirements for SUD are determined.]

C.9. Requirements for Improvement

[Furnish a list of all SUD benefits which make approval contingent upon improvement within a specific number of days.]

C.10. Other Limitations on Obtaining Covered Benefits

[Furnish a list of any other limitations imposed on obtaining SUD benefits covered by the health benefit plan.]

C.11. Comparison of NQTLs Applied to SUD and Med/Surg Benefits

[Furnish a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to SUD benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

C.12. Program of Auditing and Monitoring for Compliance

[Furnish a description of the program for auditing and monitoring the application of medical necessity criteria and other medical management standards and nonquantitative treatment limits to SUD benefits to ensure that they are not applied more stringently than those criteria or standards applied to Med/Surg benefits in the same classification.]

Section D. Pharmacy Benefits

D.1. Factors for Med/Surg Pharmacy Benefits

[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for Med/Surg conditions.]

D.2. Factors for MH Pharmacy Benefits

[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for MH conditions.]

D.3. Factors for SUD Pharmacy Benefits

[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for SUD conditions.]

D.4. Fail-First or Step Therapy for Med/Surg Pharmacy Benefits

[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for Med/Surg conditions.]

D.5. Fail-First or Step Therapy for MH Pharmacy Benefits

[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for MH conditions.]

D.6. Fail-First or Step Therapy for SUD Pharmacy Benefits

[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for SUD conditions.]

D.7. Tiering Pharmacy Drugs for Med/Surg Pharmacy Benefits

[Furnish a list of the factors considered when tiering pharmacy drugs for Med/Surg conditions.]

D.8. Tiering Pharmacy Drugs for MH Pharmacy Benefits

[Furnish a list of the factors considered when tiering pharmacy drugs for MH conditions.]

D.9. Tiering Pharmacy Drugs for SUD Pharmacy Benefits

[Furnish a list of the factors considered when tiering pharmacy drugs for SUD conditions.]

D.10. Other Limitations on Pharmacy Benefits

[Furnish a list of any other limitations imposed on obtaining pharmacy benefits covered by the health benefit plan.]

D.11. Comparison of NQTLs Applied to Pharmacy Benefits

[Provide a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to MH and SUD pharmacy benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

D.12. Program of Auditing and Monitoring For Compliance

[Describe the program for auditing and monitoring the application of prior authorization, fail-first or step therapy, or formulary tiering to ensure that standards applied to MH and SUD benefits are not applied more stringently than those criteria or standards applied to Med/Surg benefits.]

Exhibit B

Selected HEDIS Measures

Instructions

For each fully insured major medical plan subject to reporting under R20-6-1503(B) submit the HEDIS measures listed below. Please submit the information in a word-searchable PDF file which is organized and identified by the measures listed below. The reporting year is the year, from January 1 through December 31, preceding the submission of this table for which final HEDIS data has been collected.

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

1. Follow-Up After Hospitalization for Mental Illness (FUH)
2. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
3. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
4. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
5. Identification of Alcohol and Other Drug Services (IAD)
6. Mental Health Utilization (MPT)
7. Depression Screening and Follow-Up for Adolescents and Adults (DSF)
8. Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
9. Depression Remission or Response for Adolescents and Adults (DRR)
10. Unhealthy Alcohol Use Screening and Follow-Up
11. Prenatal Depression Screening and Follow-up (PND)
12. Postpartum Depression Screening and Follow-up (PDS)

Exhibit C

Complaints Related to Network Access

Instructions

Provide data on complaints received from members related to the ability to access care through network providers. Complete one table for each network utilized by fully insured, major medical plans.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit C.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity
	MH/SUD Care	**Med/Surg Care**
Member complaints regarding inability to access a provider or provider type		

Exhibit D

Percentage of Allowed Claims for Out of Network (OON) Services

Instructions

Provide data related to complaints received from members related to the ability to access care through network providers. Complete one table for each network utilized by fully insured, major medical plans.

"Inpatient facility stays" include hospitalization for scheduled procedures, admission at the direction of a physician, as well as hospitalization following the receipt of emergency services as defined at A.R.S. § 20-2801.

"Outpatient facility visits" include care which does not require hospital admission, but which is not rendered in a physician's office.

"Services obtained through network exception" are services authorized when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available pursuant to Section R20-6-1910.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit D.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Provide the percentage of all allowed claims that were for OON, for Med/Surg and for MH/SUD services.

Setting	Column A Percentage of all allowed Med/Surg specialist provider claims that were for OON services (including, for HCSOs, services obtained through network exception)	Column B Percentage of all allowed MH/SUD provider claims that were for OON services (including, for HCSOs, services obtained through network exception)	Column C The absolute difference in percentage points between Column A and Column B	Column D The ratio of Column B to Column A
Inpatient Facility Stays				

Outpatient Facility Visits				
Office Visits				

Exhibit E

Percentage of In-Network Providers Accepting New Patients

Instructions

Provide data related to providers who are accepting new patients. Complete one table for each network utilized by fully insured, major medical plans.

"Provider accepting new patients" is a provider who a member can contact directly to receive an appointment as a new patient.

"Child psychiatrist" is a psychiatrist who has received specialized training to provide treatment for children or adolescents up to the age of 18 years old.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit E.

Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Provide the total number of providers, total number of providers with open panels, and the total percentage of providers with open panels for each provider type.

	Provider Type	**Column A: Total Number of Providers**	**Column B: Total Number Accepting New Patients**	**Column C: Total Percentage Accepting New Patients (Column A / Column B)**
1	Med/Surg primary care providers			
2	Med/Surg specialist providers			
3	All MH/SUD providers			
4	Psychiatrists, including child psychiatrists			
5	Child psychiatrists			
6	Psychologists			
7	Licensed independent clinical social workers			
8	Licensed independent professional counselors			
9	Licensed independent marriage and family therapists			
10	Licensed independent substance abuse counselors			
11	Board certified behavioral analysts			
12	Nurse practitioners certified as mental health and psychiatric nurses			
13	Physician assistants certified as mental health and psychiatric physician assistants			

Exhibit F

Active Providers Listed in Network Directory by Provider Type

Instructions

Report data related to providers who are actively providing care to members in the network as evidenced through submission of claims during the reporting year. Complete one Exhibit F for each network utilized by fully insured, major medical plans.

"Child psychiatrist" is a psychiatrist who has received specialized training to provide treatment for children or adolescents up to the age of 18 years old.

"Claims" include claims for outpatient services, with dates of service during the applicable reporting period, including claims received through a date beyond the end of the applicable reporting period.

"Other MH/SUD Licensed Professionals" include licensed independent marriage and family therapists, licensed independent professional counselors, licensed independent substance abuse counselors, board certified behavioral analysts, nurse practitioners certified as mental health and psychiatric nurses, and physician assistants certified as mental health and psychiatric physician assistants.

The applicable reporting period is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit F.

Reporting Period (mm/dd/yy – mm/dd/yy)		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Psychiatrist Data

1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
2	Number of psychiatrists (including child psychiatrists) who submitted zero in-network, claims during the Applicable Reporting Period:	
3	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
4	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
5	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
6	Total number of members served by this network (insured lives, unique individuals):	
7	Ratio of psychiatrists (including child psychiatrists) to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
8	Ratio of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
9	Percentage of psychiatrists who submitted zero in-network claims (Row 2 divided by Row 1):	

Child Psychiatrist Data

10	Total number of child psychiatrists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
11	Number of child psychiatrists who submitted zero in-network claims during the Applicable Reporting Period:	
12	Number of child psychiatrists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
13	Number of child psychiatrists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
14	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
15	Total number of members under age 19 served by this network (insured lives, unique individuals):	
16	Ratio of child psychiatrists to total child covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	

17	Ratio of child psychiatrists who submitted in-network claims for 1 or more unique individuals to total child covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
18	Percentage of child psychiatrists who submitted zero in-network claims (Row 2 divided by Row 1):	
Psychologist Data		
19	Total number of psychologists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
20	Number of psychologists who submitted zero in-network claims during the Applicable Reporting Period:	
21	Number of psychologists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
22	Number of psychologists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
23	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
24	Total number of members served by this network (insured lives, unique individuals):	
25	Ratio of psychologists to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
26	Ratio of psychologists who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
27	Percentage of psychologists who submitted zero in-network claims (Row 2 divided by Row 1):	
Licensed Independent Clinical Social Worker (LICSW) Data		
28	Total number of LICSWs who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
29	Number of LICSWs who submitted zero in-network claims during the Applicable Reporting Period:	
30	Number of LICSWs who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
31	Number of LICSWs who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
32	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
33	Total number of members served by this network (insured lives, unique individuals):	
34	Ratio of LICSWs to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
35	Ratio of LICSWs who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
36	Percentage of LICSWs who submitted zero in-network claims (Row 2 divided by Row 1):	
Other MH/SUD Licensed Professional Data		
37	Total number of Other MH/SUD Licensed Professionals who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
38	Number of Other MH/SUD Licensed Professionals who submitted zero in-network claims during the Applicable Reporting Period:	
39	Number of Other MH/SUD Licensed Professionals who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
40	Number of Other MH/SUD Licensed Professionals who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
41	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
42	Total number of members served by this network (insured lives, unique individuals):	
43	Ratio of Other MH/SUD Licensed Professionals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
44	Ratio of Other MH/SUD Licensed Professionals who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
45	Percentage of Other MH/SUD Licensed Professionals who submitted zero in-network claims (Row 2 divided by Row 1):	
Primary Care Provider (PCP) Data		
46	Total number of PCPs who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
47	Number of PCPs who submitted zero in-network claims during the Applicable Reporting Period:	
48	Number of PCPs who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
49	Number of PCPs who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
50	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	

51	Total number of members served by this network (insured lives, unique individuals):	
52	Ratio of PCPs to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
53	Ratio of PCPs who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
54	Percentage of PCPs who submitted zero in-network claims (Row 2 divided by Row 1):	
	Med/Surg Specialist Provider Data	
55	Total number of Med/Surg Specialists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
56	Number of Med/Surg Specialists who submitted zero in-network claims during the Applicable Reporting Period:	
57	Number of Med/Surg Specialists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
58	Number of Med/Surg Specialists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
59	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
60	Total number of members served by this network (insured lives, unique individuals):	
61	Ratio of Med/Surg Specialists to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
62	Ratio of Med/Surg Specialists who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
63	Percentage of Med/Surg Specialists who submitted zero in-network claims (Row 2 divided by Row 1):	

Exhibit G

Provider Network Tiers

Instructions

Provide data on the percentage of providers of certain types who are placed in the lowest tier of a tiered network. Complete one Exhibit G for each network that utilizes network tiers utilized by fully insured, major medical plans.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit G.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity
Provide the percentage of providers who are placed in the lowest network tier for each provider type.		

1	Med/Surg primary care providers	
2	Med/Surg specialist providers	
3	All MH/SUD providers	
4	Psychiatrists, including child psychiatrists	
5	Child psychiatrists	
6	Psychologists	
7	Licensed independent clinical social workers	
8	Licensed independent professional counselors	
9	Licensed independent marriage and family therapists	
10	Licensed independent substance abuse counselors	
11	Board certified behavioral analysts	

12	Nurse practitioners certified as a mental health and psychiatric nurse	
13	Physician assistants certified as a mental health and psychiatric physician assistant	

Exhibit H

Formulary Tiers

Instructions

Provide a count of the total number of Chemically Distinct Drugs in each selected United States Pharmacopeia category and class, the total number of Chemically Distinct Drugs in each selected class on the formulary, and the total number of Chemically Distinct Drugs in each selected class placed in the lowest cost drug tier. Complete one Exhibit H for each formulary utilized by fully insured, major medical plans during the reporting year.

"Chemically Distinct Drug" is a drug which has its own RxNorm Concept Unique Identifier (RXCUI).
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit H.

Reporting Year:		
Formulary Name/Identifier:		
Service Area: (List all counties in the service area where this formulary is in use)		
Covered Lives: (List the number of covered lives enrolled in plans that utilized this formulary in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	United States Pharmacopeia Category and Class	**Total Number of Drugs in Class**	**Total Number of Drugs on Formulary**	**Total Number of Drugs Placed in Lowest Cost Tier**
1	Anti-Addiction/Substance Abuse Treatment Agents: Alcohol Deterrents/Anti-craving			
2	Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments			
3	Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents			
4	Anti-Addiction/Substance Abuse Treatment Agents:			
5	Antidepressants: Monoamine Oxidase Inhibitors			
6	Antidepressants: SSRIs/SNRIs			
7	Antidepressants: Tricyclics			
8	Antidepressants: Antidepressants, Other			
9	Antipsychotics: 1st Generation/Typical			
10	Antipsychotics: 2nd Generation/Atypical			
11	Antipsychotics: Treatment-Resistant			
12	Anxiolytics: Benzodiazepines			
13	Anxiolytics: SSRIs/SNRIs			
14	Anxiolytics: Anxiolytics, Other			
15	Bipolar Agents: Mood Stabilizers			
16	Bipolar Agents: Bipolar Agents, Other			
17	Blood Glucose Regulators: Antidiabetic Agents			
18	Blood Glucose Regulators: Glycemic Agents			
19	Blood Glucose Regulators: Insulins			
20	Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Amphetamines			
21	Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines			
22	Gastrointestinal Agents: Antispasmodics, Gastrointestinal			
23	Gastrointestinal Agents: Histamine2 (H2) Receptor Antagonists			
24	Gastrointestinal Agents: Irritable Bowel Syndrome Agents			
25	Gastrointestinal Agents: Laxatives			
26	Gastrointestinal Agents: Protectants			
27	Gastrointestinal Agents: Proton Pump Inhibitors			

28	Gastrointestinal Agents: Gastrointestinal Agents, Other			

Exhibit I

Prior Authorization Denial Rates for Which No Claim Subsequently Submitted (Med/Surg v. MH/SUD)

Instructions
Provide data on the prior authorization denial rates for which no claim was subsequently submitted. Complete one Exhibit I for each network utilized by fully insured, major medical plans.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit I.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)

Prior Authorization Denial Rates for which No Claim Subsequently Submitted				
		Setting		
Benefit Category & Denial Reason		**Inpatient Facility Stays**	**Outpatient Facility Visits**	**Office Visits**
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD – Administrative			

Exhibit J

Claim Denial Rates for Med/Surg v. MH/SUD

Instructions
Provide data on the claim denial rates for Med/Surg versus MH/SUD benefits. Complete one Exhibit J for each network utilized by fully insured, major medical plans.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit J.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits

Product Types: (Check all that apply)		☐PPO ☐POS			☐HMO (HCSO) ☐Indemnity	
Claim Denials						

Benefit Category & Denial Reason		Setting		
		Inpatient Facility Stays	Outpatient Facility Visits	Office Visits
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD – Administrative			

Exhibit K

Rates of Approval only for Lower Level of Care for Med/Surg v. MH/SUD Care

Instructions

Provide data on denial of the requested care and approval of a lower level of care. Complete one Exhibit K for each network utilized by fully insured, major medical plans.

A "prior authorization is authorized for a lower level of care" when a request is received for inpatient care, but only outpatient facility care or office visits is approved; or when a request is received for outpatient facility care but only office visits are approved.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit K.

Field		
Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
Rates at which the Insurer Approved a Lower Level of Care		

Benefit Category & Denial Reason		Setting		
		Inpatient Facility Stays	Outpatient Facility Visits	Office Visits
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD – Administrative			

Exhibit L

Allowed Amounts, Med/Surg v. MH/SUD, using Medicare Benchmark

Instructions

Provide data on the Weighted Average Allowed Amounts for certain physician types compared to the Medicare allowed amount. Complete one Exhibit L for each network utilized by fully insured, major medical plans.

"Weighted Average Allowed Amount" is the sum of the allowed amounts for every claim for the indicated CPT code that was allowed for these providers, divided by the total number of claims for the indicated CPT code allowed for such providers.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit L.

Reporting Year		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Primary Care Physicians ("PCPs") and Non-Psychiatrist Medical/Surgical Specialist Physicians (Combined)					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 99213	CPT 99214	CPT 99213	CPT 99214	CPT 99213	CPT 99214
$	$	$	$	%	%
Psychiatrists, Including Child Psychiatrists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%
Physical Therapists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 97162	CPT 97110	CPT 97162	CPT 97110	CPT 97162	CPT 97110
$		$		%	
Psychologists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%
Licensed Independent Clinical Social Workers					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%

Exhibit M

Credentialing Timeframes, Med/Surg v. MH/SUD

Instructions
Provide data on the average time to credential and load providers of certain types. Complete one Exhibit M providing these averages across all fully insured, major medical plans subject to reporting under R20-6-1503(B).

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit M.

Reporting Year:		
Covered Lives: (List the number of covered lives enrolled in plans subject to reporting in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	Provider Type	**Average time to conclude the process of credentialing and load the applicant's information into the health insurer's billing system**	**Average time to load the provider's information into the health insurer's network directory**
1	Med/Surg Providers		
2	All MH/SUD Providers		
3	Psychiatrists, including child psychiatrists		
4	Child psychiatrists		
5	Psychologists		
6	Licensed independent clinical social workers		
7	Licensed independent professional counselors		
8	Licensed independent marriage and family therapists		
9	Licensed independent substance abuse counselors		
10	Board certified behavioral analysts		
11	Nurse practitioners certified as a mental health and psychiatric nurse		
12	Physician assistants certified as a mental health and psychiatric physician assistant		

Exhibit N

Medical Management Techniques by Benefit

Instructions
Indicate which of the identified medical management categories apply to the identified list of benefits. Complete one Exhibit N for each fully insured, major medical plan. If the application of medical management standards varies across plans, submit one Exhibit N for each variation.

The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit N.

Reporting Year:		
Covered Lives: (List the number of covered lives enrolled in plans subject to reporting in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	Benefit Name	**Medical Management**			
		Prior authorization/ Precertification Required	**Fail-First or Step Therapy Requirements Apply**	**Concurrent Authorization Requirements Apply**	**Retrospective Review Applies**
1	Allergy Testing				
2	Autism Spectrum Disorders				

2a		Applied Behavior Analysis (ABA) Based Therapies				
2b		Evaluation and Assessment Services				
2c		Habilitative Care				
2d		Rehabilitative Care				
2e		Pharmacy Care and Medication				
2f		Psychiatric Care				
2g		Psychological Care, Including Family Counseling				
3	Drugs – Generic					
4	Drugs - Preferred Brand					
5	Drugs - Non-Preferred Brand					
6	Drugs – Specialty					
7	Durable Medical Equipment					
8	Emergency Room Services					
8a		Med/Surg				
8b		Behavioral Health/MH				
8c		SUD				
9	Emergency Transportation/Ambulance					
9a		Med/Surg				
9b		Behavioral Health/MH				
9c		SUD				
10	Habilitative Occupational Therapy – Adult					
11	Habilitative Occupational Therapy – Child					
12	Habilitative Physical Therapy - Adult					
13	Habilitative Physical Therapy - Child					
14	Habilitative Speech Therapy - Adult					
15	Habilitative Speech Therapy - Child					
16	Home Health Care Services					
17	Hospice Services					
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19	Inpatient Hospital Services (e.g., Hospital Stay)					
19a		Med/Surg				
19b		Behavioral Health/MH				
19c		SUD				
20	Inpatient Physician and Surgical Services					
20a		Med/Surg				
20b		Behavioral Health/MH				
20c		SUD				
21	Intensive Outpatient Therapy for MH					
22	Intensive Outpatient Therapy for SUD					
23	Laboratory Outpatient and Professional Services					
24	Long-Term/Custodial Nursing Home Care					
25	Other Practitioner Office Visit (Nurse, Physician Assistant)					
25a		Med/Surg				
25b		Behavioral Health/MH				
25c		SUD				
26	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					
27	Outpatient Surgery Physician/Surgical Services					
28	Partial Hospitalization for Behavioral Health/MH					
29	Partial Hospitalization for SUD					
30	Postpartum MH/SUD					
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30c		SUD				
31	Preventive Care/Screening/Genetic Testing/Immunization – Adult					
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32	Preventive Care/Screening/Genetic Testing/Immunization – Child					
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NOTICES OF SUBSTANTIVE POLICY STATEMENT

The *Administrative Procedure Act* (APA) requires the publication of Notices of Substantive Policy Statement issued by agencies (A.R.S. § 41-1013(B)(9)).

Substantive policy statements are written expressions which inform the general public of an agency's current approach to rule or regulation practice.

Substantive policy statements are advisory only. A substantive policy statement does not include internal procedural documents that only affect an agency's internal procedures and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the APA.

If you believe that a substantive policy statement does impose additional requirements or penalties on regulated parties, you may petition the agency under A.R.S. § 41-1033 for a review of the statement.

NOTICE OF SUBSTANTIVE POLICY STATEMENT
ARIZONA STATE BOARD OF DENTAL EXAMIENRS

[M21-08]

1. Title of the Substantive Policy Statement and the number by which the Substantive Policy Statement is referenced (if applicable):

Agency Substantive Policy Statement #26: Opioid Continuing Education

2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:

Issued and Effective: April 6, 2018, revised June 7, 2019

3. Summary of the contents of the substantive policy statement:

A health professional who is authorized under this title to prescribe Schedule II controlled substances and who has a valid United States Drug Enforcement Administration Registration Number or who is authorized under Chapter 18 of this title to dispense controlled substances shall complete a minimum of three hours of opioid-related, substance use disorder-related or addiction-related continuing medical education each license renewal cycle as part of any continuing education requirements for that health professional.

The Arizona State Board of Dental Examiners ("Board") current rules on continuing education requirements for dentists, specifically A.A.C. R4-11-1203(3), requires a dentist to obtain at least three hours of continuing education in chemical dependency, which may include tobacco cessation, as part of the 72 continuing education hours required each license renewal cycle.

4. Federal or state constitutional provision; federal or state statute, administrative rule, or regulation; or final court judgment that underlies the substantive policy statement:

A.A.C. R4-11-1203(3)

5. A statement as to whether the substantive policy statement is a new statement or a revision:

This is a revision.

6. The agency contact person who can answer questions about the substantive policy statement:

Name: Ryan Edmonson
Address: Arizona State Board of Dental Examiners
1740 W. Adams St., Suite 2470
Phoenix, AZ 85007
Telephone: (602) 242-1492
Fax: (602) 242-1445
Email: info@dentalboard.az.gov
Website: dentalboard.az.gov

7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:

Copies of Substantive Policy Statement number 26 are available from the Arizona State Board of Dental Examiners, located at 1740 W. Adams St., Suite 2470, Phoenix, AZ 85007 and is available on our website at dentalboard.az.gov.

NOTICE OF SUBSTANTIVE POLICY STATEMENT

ARIZONA STATE BOARD OF DENTAL EXAMIENRS

[M21-09]

1. Title of the Substantive Policy Statement and the number by which the Substantive Policy Statement is referenced (if applicable):

Agency Substantive Policy Statement #27: Dental Assistant Scope of Practice – Digital Impressions

2. Date the substantive policy statement was issued and the effective date of the policy statement if different from the issuance date:

Issued and Effective: February 4, 1999, revised March 6, 2020

3. Summary of the contents of the substantive policy statement:

A dental assistant shall not perform the following procedures or functions: Taking final impressions for any activating orthodontic appliance, fixed or removable prosthesis.

The amendment to A.A.C. R4-11-702(4) predates recent advances in dental technology, including the use of digital impressions, which is an alternative to the impression tray and alginate paste process, which was often messy, had an unpleasant taste, and caused gagging in many patients.

Accordingly, the Board does not interpret A.A.C. R4-11-702(4) as prohibiting a dental assistant from taking digital impressions, provided the digital impression is done under the direct supervision of a dentist, and the dentist approves the impression and is the one who submits it for processing.

4. Federal or state constitutional provision: federal or state statute, administrative rule, or regulation: or final court judgment that underlies the substantive policy statement:

A.A.C. R4-11-702(4)

5. A statement as to whether the substantive policy statement is a new statement or a revision:

This is a revision.

6. The agency contact person who can answer questions about the substantive policy statement:

Name:	Ryan Edmonson
Address:	Arizona State Board of Dental Examiners 1740 W. Adams St., Suite 2470 Phoenix, AZ 85007
Telephone:	(602) 242-1492
Fax:	(602) 242-1445
Email:	info@dentalboard.az.gov
Website:	dentalboard.az.gov

7. Information about where a person may obtain a copy of the substantive policy statement and the costs for obtaining the policy statement:

Copies of Substantive Policy Statement number 27 are available from the Arizona State Board of Dental Examiners, located at 1740 W. Adams St., Suite 2470, Phoenix, AZ 85007 and is available on our website at dentalboard.az.gov.

GOVERNOR EXECUTIVE ORDER

Executive Order 2020-02 is being reproduced in each issue of the *Administrative Register* as a notice to the public regarding state agencies' rulemaking activities.

This order has been reproduced in its entirety as submitted.

EXECUTIVE ORDER 2020-02

Moratorium on Rulemaking to Promote Job Creation and Economic Development; Implementation of Licensing Reform Policies

[M20-01]

WHEREAS, government regulations should be as limited as possible; and

WHEREAS, burdensome regulations inhibit job growth and economic development; and

WHEREAS, protecting the public health, peace and safety of the residents of Arizona is a top priority of state government; and

WHEREAS, in 2015, the State of Arizona implemented a moratorium on all new regulatory rulemaking by State agencies through executive order, and renewed the moratorium in 2016, 2017, 2018 and 2019; and

WHEREAS, the State of Arizona eliminated or improved 637 burdensome regulations in 2019 and a total of 2,289 needless regulations have been eliminated or improved since 2015; and

WHEREAS, estimates show these eliminations saved job creators $53.9 million in operating costs in 2019 and a total of over $134.3 million in savings since 2015; and

WHEREAS, in 2019, for every one new necessary rule added to the Administrative Code, five have been repealed or improved; and

WHEREAS, approximately 354,000 private sector jobs have been added to Arizona since January 2015; and

WHEREAS, all government agencies of the State of Arizona should continue to promote customer-service-oriented principles for the people that it serves; and

WHEREAS, each State agency shall continue to conduct a critical and comprehensive review of its administrative rules and take action to reduce the regulatory burden, administrative delay and legal uncertainty associated with government regulation while protecting the health and safety of residents; and

WHEREAS, each State agency should continue to evaluate its administrative rules using any available and reliable data and performance metrics; and

WHEREAS, Article 5, Section 4 of the Arizona Constitution and Title 41, Chapter 1, Article 1 of the Arizona Revised Statutes vests the executive power of the State of Arizona in the Governor.

NOW, THEREFORE, I, Douglas A. Ducey, by virtue of the authority vested in me by the Constitution and laws of the State of Arizona hereby declare the following:

1. A State agency subject to this Order shall not conduct any rulemaking, whether informal or formal, without the prior written approval of the Office of the Governor. In seeking approval, a State agency shall address one or more of the following as justifications for the rulemaking:
   a. To fulfill an objective related to job creation, economic development or economic expansion in this State.
   b. To reduce or ameliorate a regulatory burden while achieving the same regulatory objective.
   c. To prevent a significant threat to the public health, peace or safety.
   d. To avoid violating a court order or federal law that would result in sanctions by a federal court for failure to conduct the rulemaking action.
   e. To comply with a federal statutory or regulatory requirement if such compliance is related to a condition for the receipt of federal funds or participation in any federal program.
   f. To comply with a state statutory requirement.
   g. To fulfill an obligation related to fees or any other action necessary to implement the State budget that is certified by the Governor's Office of Strategic Planning and Budgeting.
   h. To promulgate a rule or other item that is exempt from Title 41, Chapter 6, Arizona Revised Statutes, pursuant to section 41-1005, Arizona Revised Statutes.
   i. To address matters pertaining to the control, mitigation or eradication of waste, fraud or abuse within an agency or wasteful, fraudulent or abusive activities perpetrated against an agency.
   j. To eliminate rules which are antiquated, redundant or otherwise no longer necessary for the operation of state government.
2. A State agency that submits a rulemaking request pursuant to this Order shall recommend for consideration by the Office of the Governor at least ***three*** existing rules to eliminate for every ***one*** additional rule requested by the agency.

3. A State agency that submits a rulemaking exemption request pursuant to this Order shall include with their request an analysis of how small businesses may be impacted by any newly proposed rules or rule modifications.
4. A State agency subject to this Order shall not publicize any directives, policy statements, documents or forms on its website unless such are explicitly authorized by the Arizona Revised Statutes or Arizona Administrative Code. Any material that is not specifically authorized must be removed immediately.
5. A State agency that issues occupational or professional licenses shall prominently post on the agency's website landing page all current state policies that ease licensing burdens and the exact steps applicants must complete to receive their license using these policies. State agencies should provide information that applies to all applicants, but have a designated area on such landing page that includes licensing information specifically for military spouses, active duty service members and veterans and all policies that make it easier for these applicant groups to receive their license. Examples of reduced licensing burdens include universal recognition of out-of-state licenses, availability of temporary licenses, fee waivers, exam exemptions and/or allowing an applicant to substitute military education or experience for licensing requirements. A landing page feature may link to an internal agency web page with more information, if necessary. All information must be easy to locate and written in clear and concise language.
6. All state agencies that are required to issue occupational or professional licenses by universal recognition (established by section 32-4302, Arizona Revised Statutes) must track all applications received for this license type. Before any agency denies a professional or occupational license applied for under section 32-4302, Arizona Revised Statutes, the agency shall submit the application and justification for denial to the Office of the Governor for review before any official action is taken by the agency. The Office of the Governor should be notified of any required timeframes, whether in statute or rule, for approval or denial of the license by the agency.
7. For the purposes of this Order, the term "State agencies" includes, without limitation, all executive departments, agencies, offices, and all state boards and commissions, except for: (a) any State agency that is headed by a single elected State official; (b) the Corporation Commission; and (c) any board or commission established by ballot measure during or after the November 1998 general election. Those state agencies, boards and commissions excluded from this Order are strongly encouraged to voluntarily comply with this Order in the context of their own rulemaking processes.
8. This Order does not confer any legal rights upon any persons and shall not be used as a basis for legal challenges to rules, approvals, permits, licenses or other actions or to any inaction of a State agency. For the purposes of this Order, "person," "rule" and "rulemaking" have the same meanings prescribed in section 41-1001, Arizona Revised Statutes.

IN WITNESS THEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Arizona.

Douglas A. Ducey
GOVERNOR

DONE at the Capitol in Phoenix on this 13th day of January in the Year Two Thousand and Twenty and of the Independence of the United States of America the Year Two Hundred and Forty-Fourth.

ATTEST:

Katie Hobbs
SECRETARY OF STATE

REGISTER INDEXES

The *Register* is published by volume in a calendar year (See "General Information" in the front of each issue for more information).

Abbreviations for rulemaking activity in this Index include:

PROPOSED RULEMAKING
PN = Proposed new Section
PM = Proposed amended Section
PR = Proposed repealed Section
P# = Proposed renumbered Section

SUPPLEMENTAL PROPOSED RULEMAKING
SPN = Supplemental proposed new Section
SPM = Supplemental proposed amended Section
SPR = Supplemental proposed repealed Section
SP# = Supplemental proposed renumbered Section

FINAL RULEMAKING
FN = Final new Section
FM = Final amended Section
FR = Final repealed Section
F# = Final renumbered Section

SUMMARY RULEMAKING
PROPOSED SUMMARY
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PSMM = Proposed Summary amended Section
PSMR = Proposed Summary repealed Section
PSM# = Proposed Summary renumbered Section
FINAL SUMMARY
FSMN = Final Summary new Section
FSMM = Final Summary amended Section
FSMR = Final Summary repealed Section
FSM# = Final Summary renumbered Section

EXPEDITED RULEMAKING
PROPOSED EXPEDITED
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PEM = Proposed Expedited amended Section
PER = Proposed Expedited repealed Section
PE# = Proposed Expedited renumbered Section
SUPPLEMENTAL EXPEDITED
SPEN = Supplemental Proposed Expedited new Section
SPEM = Supplemental Proposed Expedited amended Section
SPER = Supplemental Proposed Expedited repealed Section
SPE# = Supplemental Proposed Expedited renumbered Section
FINAL EXPEDITED
FEN = Final Expedited new Section
FEM = Final Expedited amended Section
FER = Final Expedited repealed Section
FE# = Final Expedited renumbered Section

EXEMPT RULEMAKING
EXEMPT
XN = Exempt new Section
XM = Exempt amended Section
XR = Exempt repealed Section
X# = Exempt renumbered Section
EXEMPT PROPOSED
PXN = Proposed Exempt new Section
PXM = Proposed Exempt amended Section
PXR = Proposed Exempt repealed Section
PX# = Proposed Exempt renumbered Section
EXEMPT SUPPLEMENTAL PROPOSED
SPXN = Supplemental Proposed Exempt new Section
SPXR = Supplemental Proposed Exempt repealed Section
SPXM = Supplemental Proposed Exempt amended Section
SPX# = Supplemental Proposed Exempt renumbered Section
FINAL EXEMPT RULEMAKING
FXN = Final Exempt new Section
FXM = Final Exempt amended Section
FXR = Final Exempt repealed Section
FX# = Final Exempt renumbered Section

EMERGENCY RULEMAKING
EN = Emergency new Section
EM = Emergency amended Section
ER = Emergency repealed Section
E# = Emergency renumbered Section
EEXP = Emergency expired

RECODIFICATION OF RULES
RC = Recodified

REJECTION OF RULES
RJ = Rejected by the Attorney General

TERMINATION OF RULES
TN = Terminated proposed new Sections
TM = Terminated proposed amended Section
TR = Terminated proposed repealed Section
T# = Terminated proposed renumbered Section

RULE EXPIRATIONS
EXP = Rules have expired
See also "emergency expired" under emergency rulemaking

CORRECTIONS
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RULES EFFECTIVE DATES CALENDAR

A.R.S. § 41-1032(A), as amended by Laws 2002, Ch. 334, § 8 (effective August 22, 2002), states that a rule generally becomes effective 60 days after the day it is filed with the Secretary of State's Office. The following table lists filing dates and effective dates for rules that follow this provision. Please also check the rulemaking Preamble for effective dates.

January		February		March		April		May		June	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
1/1	3/2	2/1	4/2	3/1	4/30	4/1	5/31	5/1	6/30	6/1	7/31
1/2	3/3	2/2	4/3	3/2	5/1	4/2	6/1	5/2	7/1	6/2	8/1
1/3	3/4	2/3	4/4	3/3	5/2	4/3	6/2	5/3	7/2	6/3	8/2
1/4	3/5	2/4	4/5	3/4	5/3	4/4	6/3	5/4	7/3	6/4	8/3
1/5	3/6	2/5	4/6	3/5	5/4	4/5	6/4	5/5	7/4	6/5	8/4
1/6	3/7	2/6	4/7	3/6	5/5	4/6	6/5	5/6	7/5	6/6	8/5
1/7	3/8	2/7	4/8	3/7	5/6	4/7	6/6	5/7	7/6	6/7	8/6
1/8	3/9	2/8	4/9	3/8	5/7	4/8	6/7	5/8	7/7	6/8	8/7
1/9	3/10	2/9	4/10	3/9	5/8	4/9	6/8	5/9	7/8	6/9	8/8
1/10	3/11	2/10	4/11	3/10	5/9	4/10	6/9	5/10	7/9	6/10	8/9
1/11	3/12	2/11	4/12	3/11	5/10	4/11	6/10	5/11	7/10	6/11	8/10
1/12	3/13	2/12	4/13	3/12	5/11	4/12	6/11	5/12	7/11	6/12	8/11
1/13	3/14	2/13	4/14	3/13	5/12	4/13	6/12	5/13	7/12	6/13	8/12
1/14	3/15	2/14	4/15	3/14	5/13	4/14	6/13	5/14	7/13	6/14	8/13
1/15	3/16	2/15	4/16	3/15	5/14	4/15	6/14	5/15	7/14	6/15	8/14
1/16	3/17	2/16	4/17	3/16	5/15	4/16	6/15	5/16	7/15	6/16	8/15
1/17	3/18	2/17	4/18	3/17	5/16	4/17	6/16	5/17	7/16	6/17	8/16
1/18	3/19	2/18	4/19	3/18	5/17	4/18	6/17	5/18	7/17	6/18	8/17
1/19	3/20	2/19	4/20	3/19	5/18	4/19	6/18	5/19	7/18	6/19	8/18
1/20	3/21	2/20	4/21	3/20	5/19	4/20	6/19	5/20	7/19	6/20	8/19
1/21	3/22	2/21	4/22	3/21	5/20	4/21	6/20	5/21	7/20	6/21	8/20
1/22	3/23	2/22	4/23	3/22	5/21	4/22	6/21	5/22	7/21	6/22	8/21
1/23	3/24	2/23	4/24	3/23	5/22	4/23	6/22	5/23	7/22	6/23	8/22
1/24	3/25	2/24	4/25	3/24	5/23	4/24	6/23	5/24	7/23	6/24	8/23
1/25	3/26	2/25	4/26	3/25	5/24	4/25	6/24	5/25	7/24	6/25	8/24
1/26	3/27	2/26	4/27	3/26	5/25	4/26	6/25	5/26	7/25	6/26	8/25
1/27	3/28	2/27	4/28	3/27	5/26	4/27	6/26	5/27	7/26	6/27	8/26
1/28	3/29	2/28	4/29	3/28	5/27	4/28	6/27	5/28	7/27	6/28	8/27
1/29	3/30			3/29	5/28	4/29	6/28	5/29	7/28	6/29	8/28
1/30	3/31			3/30	5/29	4/30	6/29	5/30	7/29	6/30	8/29
1/31	4/1			3/31	5/30			5/31	7/30		

July		August		September		October		November		December	
Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date	Date Filed	Effective Date
7/1	8/30	8/1	9/30	9/1	10/31	10/1	11/30	11/1	12/31	12/1	1/30
7/2	8/31	8/2	10/1	9/2	11/1	10/2	12/1	11/2	1/1	12/2	1/31
7/3	9/1	8/3	10/2	9/3	11/2	10/3	12/2	11/3	1/2	12/3	2/1
7/4	9/2	8/4	10/3	9/4	11/3	10/4	12/3	11/4	1/3	12/4	2/2
7/5	9/3	8/5	10/4	9/5	11/4	10/5	12/4	11/5	1/4	12/5	2/3
7/6	9/4	8/6	10/5	9/6	11/5	10/6	12/5	11/6	1/5	12/6	2/4
7/7	9/5	8/7	10/6	9/7	11/6	10/7	12/6	11/7	1/6	12/7	2/5
7/8	9/6	8/8	10/7	9/8	11/7	10/8	12/7	11/8	1/7	12/8	2/6
7/9	9/7	8/9	10/8	9/9	11/8	10/9	12/8	11/9	1/8	12/9	2/7
7/10	9/8	8/10	10/9	9/10	11/9	10/10	12/9	11/10	1/9	12/10	2/8
7/11	9/9	8/11	10/10	9/11	11/10	10/11	12/10	11/11	1/10	12/11	2/9
7/12	9/10	8/12	10/11	9/12	11/11	10/12	12/11	11/12	1/11	12/12	2/10
7/13	9/11	8/13	10/12	9/13	11/12	10/13	12/12	11/13	1/12	12/13	2/11
7/14	9/12	8/14	10/13	9/14	11/13	10/14	12/13	11/14	1/13	12/14	2/12
7/15	9/13	8/15	10/14	9/15	11/14	10/15	12/14	11/15	1/14	12/15	2/13
7/16	9/14	8/16	10/15	9/16	11/15	10/16	12/15	11/16	1/15	12/16	2/14
7/17	9/15	8/17	10/16	9/17	11/16	10/17	12/16	11/17	1/16	12/17	2/15
7/18	9/16	8/18	10/17	9/18	11/17	10/18	12/17	11/18	1/17	12/18	2/16
7/19	9/17	8/19	10/18	9/19	11/18	10/19	12/18	11/19	1/18	12/19	2/17
7/20	9/18	8/20	10/19	9/20	11/19	10/20	12/19	11/20	1/19	12/20	2/18
7/21	9/19	8/21	10/20	9/21	11/20	10/21	12/20	11/21	1/20	12/21	2/19
7/22	9/20	8/22	10/21	9/22	11/21	10/22	12/21	11/22	1/21	12/22	2/20
7/23	9/21	8/23	10/22	9/23	11/22	10/23	12/22	11/23	1/22	12/23	2/21
7/24	9/22	8/24	10/23	9/24	11/23	10/24	12/23	11/24	1/23	12/24	2/22
7/25	9/23	8/25	10/24	9/25	11/24	10/25	12/24	11/25	1/24	12/25	2/23
7/26	9/24	8/26	10/25	9/26	11/25	10/26	12/25	11/26	1/25	12/26	2/24
7/27	9/25	8/27	10/26	9/27	11/26	10/27	12/26	11/27	1/26	12/27	2/25
7/28	9/26	8/28	10/27	9/28	11/27	10/28	12/27	11/28	1/27	12/28	2/26
7/29	9/27	8/29	10/28	9/29	11/28	10/29	12/28	11/29	1/28	12/29	2/27
7/30	9/28	8/30	10/29	9/30	11/29	10/30	12/29	11/30	1/29	12/30	2/28
7/31	9/29	8/31	10/30			10/31	12/30			12/31	3/1

REGISTER PUBLISHING DEADLINES

The Secretary of State's Office publishes the Register weekly. There is a three-week turnaround period between a deadline date and the publication date of the Register. The weekly deadline dates and issue dates are shown below. Council meetings and Register deadlines do not correlate. Also listed are the earliest dates on which an oral proceeding can be held on proposed rulemakings or proposed delegation agreements following publication of the notice in the Register.

Deadline Date (paper only) Friday, 5:00 p.m.	*Register* Publication Date	Oral Proceeding may be scheduled on or after
November 13, 2020	December 4, 2020	January 4, 2021
November 20, 2020	December 11, 2020	January 11, 2021
November 27, 2020	December 18, 2020	January 19, 2021
December 4, 2020	December 25, 2020	January 25, 2021
December 11, 2020	January 1, 2021	February 1, 2021
December 18, 2020	January 8, 2021	February 8, 2021
December 24, 2020	January 15, 2021	February 16, 2021
December 31, 2021	January 22, 2021	February 22, 2021
January 8, 2021	January 29, 2021	March 1, 2021
January 15, 2021	February 5, 2021	March 8, 2021
January 22, 2021	February 12, 2021	March 15, 2021
January 29, 2021	February 19, 2021	March 22, 2021
February 5, 2021	February 26, 2021	March 29, 2021
February 12, 2021	March 5, 2021	April 5, 2021
February 19, 2021	March 12, 2021	April 12, 2021
February 26, 2021	March 19, 2021	April 19, 2021
March 5, 2021	March 26, 2021	April 26, 2021
March 12, 2021	April 2, 2021	May 3, 2021
March 19, 2021	April 9, 2021	May 10, 2021
March 26, 2021	April 16, 2021	May 17, 2021
April 2, 2021	April 23, 2021	May 24, 2021
April 9, 2021	April 30, 2021	June 1, 2021
April 16, 2021	May 7, 2021	June 7, 2021
April 23, 2021	May 14, 2021	June 14, 2021
April 30, 2021	May 21, 2021	June 21, 2021
May 7, 2021	May 28, 2021	June 28, 2021
May 14, 2021	June 4, 2021	July 6, 2021
May 21, 2021	June 11, 2021	July 12, 2021
May 28, 2021	June 18, 2021	July 19, 2021
June 4, 2021	June 25, 2021	July 26, 2021

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES

The following deadlines apply to all Five-Year Review Reports and any adopted rule submitted to the Governor's Regulatory Review Council. Council meetings and *Register* deadlines do not correlate. We publish these deadlines under A.R.S. § 41-1013(B)(15).

All rules and Five-Year Review Reports are due in the Council office by 5 p.m. of the deadline date. The Council's office is located at 100 N. 15th Ave., Suite 305, Phoenix, AZ 85007. For more information, call (602) 542-2058 or visit http://grrc.az.gov.

GOVERNOR'S REGULATORY REVIEW COUNCIL DEADLINES FOR 2021

(MEETING DATES ARE SUBJECT TO CHANGE)

[M20-42]

DEADLINE FOR PLACEMENT ON AGENDA*	FINAL MATERIALS SUBMITTED TO COUNCIL	DATE OF COUNCIL STUDY SESSION	DATE OF COUNCIL MEETING
Tuesday November 17, 2020	*Tuesday* December 22, 2020	*Tuesday* December 29, 2020	*Tuesday* January 5, 2021
Tuesday December 29, 2020	*Tuesday* January 19, 2021	*Tuesday* January 26, 2021	*Tuesday* February 2, 2021
Tuesday January 19, 2021	*Tuesday* February 16, 2021	*Tuesday* February 23, 2021	*Tuesday* March 2, 2021
Tuesday February 16, 2021	*Tuesday* March 23, 2021	*Tuesday* March 30, 2021	*Tuesday* April 6, 2021
Tuesday March 23, 2021	*Tuesday* April 20, 2021	*Tuesday* April 27, 2021	*Tuesday* May 4, 2021
Tuesday April 20, 2021	*Tuesday* May 18, 2021	***Wednesday*** May 26, 2021	*Tuesday* June 1, 2021
Tuesday May 18, 2021	*Tuesday* June 22, 2021	*Tuesday* June 29, 2021	***Wednesday*** July 7, 2021
Tuesday June 22, 2021	*Tuesday* July 20, 2021	*Tuesday* July 27, 2021	*Tuesday* August 3, 2021
Tuesday July 20, 2021	*Tuesday* August 24, 2021	*Tuesday* August 31, 2021	***Wednesday*** September 8, 2021
Tuesday August 24, 2021	*Tuesday* September 21, 2021	*Tuesday* September 28, 2021	*Tuesday* October 5, 2021
Tuesday September 21, 2021	*Tuesday* October 19, 2021	*Tuesday* October 26, 2021	*Tuesday* November 2, 2021
Tuesday October 19, 2021	*Tuesday* November 23, 2021	*Tuesday* November 30, 2021	*Tuesday* December 7, 2021
Tuesday November 23, 2021	*Tuesday* December 21, 2021	*Tuesday* December 28, 2021	*Tuesday* January 4, 2022
Tuesday December 21, 2021	*Tuesday* January 18, 2022	*Tuesday* January 25, 2022	*Tuesday* February 1, 2022

* Materials must be submitted by **5 PM** on dates listed as a deadline for placement on a particular agenda. Placement on a particular agenda is not guaranteed.