DEPARTMENT OF HEALTH SERVICES (Expedited Rulemaking)
Title 9, Chapter 17

Amend: R9-17-101, R9-17-102, R9-17-103, R9-17-107, Table 1.1, R9-17-202, R9-17-203, R9-17-204, R9-17-303, R9-17-304, R9-17-305, R9-17-306, R9-17-307, R9-17-308, R9-17-310, R9-17-311, R9-17-312, R9-17-316, R9-17-317.01, Table 3.1, R9-17-319, R9-17-322, R9-17-323, R9-17-324
GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - EXPEDITED RULEMAKING

MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 11, 2022

SUBJECT: Department of Health Services
Title 9, Chapter 17

Amend: R9-17-101, R9-17-102, R9-17-103, R9-17-107, Table 1.1,
R9-17-202, R9-17-203, R9-17-204, R9-17-303, R9-17-304,
R9-17-305, R9-17-306, R9-17-307, R9-17-308, R9-17-310,
R9-17-311, R9-17-312, R9-17-316, R9-17-317.01, Table 3.1,
R9-17-319, R9-17-322, R9-17-323, R9-17-324

Summary:

This expedited rulemaking from the Department of Health Services relates to rules in Title 9, Chapter 17 regarding the Medical Marijuana Program. In this expedited rulemaking the Department seeks to amend the rules to comply A.R.S. Title 36, Chapter 28.1 and Laws 2021, Ch. 439. A.R.S. Title 36, Chapter 28.1 specifies requirements for the regulation of medical marijuana dispensaries and dispensary agents, as well as for qualifying patients and designated caregivers. The Department is seeking to adopt rules to implement the statutes. Laws 2021, Ch. 439 made changes to the requirements for medical marijuana dispensaries and others regulated under these rules. The changes include allowing an individual to provide a level 1 fingerprint clearance card, issued according to A.R.S. § 41-1758.07, rather than submitting fingerprints for a background check; making changes to medical marijuana testing requirements; requiring the addition of a time frame for testing; and allowing marijuana facility agents to work in dispensaries.
Additionally, the Department was ordered in Maricopa County Court (Case No. CV2021-003384) to accept application for nonprofit medical marijuana registration certificates by December 31, 2022. Lastly, the Department is also addressing issues identified in a previous 5YRR of these rules approved by the Council on July 7, 2021.

The Department received approval from the rulemaking moratorium to initiate this rulemaking on April 25, 2022 and final approval to submit to the Council on July 12, 2022.

1. **Do the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)?**

   Yes. The Department states that the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)(1), (3), (5), (6), and (7).

2. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   Yes, the Department cites to both general and specific statutory authority.

3. **Do the rules establish a new fee or contain a fee increase?**

   No, the rules do not establish a new fee or contain a fee increase.

4. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

   The Department indicates they did not receive any comments on the proposed rules. However, the Department indicates they received a question from a stakeholder about the rules. The Department properly answered the stakeholder questions.

5. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

   No, the Department did not make any changes between the proposed expedited rulemaking and the final expedited rulemaking.

6. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

   Not applicable. There are no corresponding federal laws.
7. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

A registration certificate for a dispensary, issued according to A.R.S. § 36-2804, or laboratory, issued according to A.R.S. § 36-2804.07, is specific to the certificate holder, type of facility, facility location, and scope of services provided. As such, a general permit is not applicable and is not used.

8. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

The Department did not review or rely on any study for this expedited rulemaking.

9. **Conclusion**

As mentioned above, the Department is seeking to amend the rules to comply with revised legislation, comply with a recent court order, and address issues identified in a previous 5YRR of these rules.

This expedited rulemaking does not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated, but reduce a burden due to outdated requirements without compromising health and safety. These rules will reduce the economic burden on all applicants, as well as the Department.

If approved, this rulemaking would be effective immediately upon the Department filing the Notice of Final Expedited Rulemaking and Certificate of Approval with the Secretary of State. The Department meets the criteria for Expedited Rulemaking pursuant to A.R.S. § 41-1027(A)(1), (3), (5), (6), and (7). Council staff recommends approval of this expedited rulemaking.
July 12, 2022

**VIA EMAIL:** grrc@azdoa.gov  
Nicole Sornsin, Chair  
Governor’s Regulatory Review Council  
Arizona Department of Administration  
100 N. 15th Avenue, Suite 305  
Phoenix, AZ 85007

RE: Department of Health Services, 9 A.A.C. 17, Articles 1-3, Expedited Rulemaking

Dear Ms. Sornsin:

1. **The close of record date:** June 27, 2022

2. **Explanation of how the expedited rule meets the criteria in A.R.S. § 41-1027(A):**  
The rulemaking does not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of regulated persons. In a rulemaking pursuant to Laws 2021, Ch. 439, the Department is amending the rules to reduce the burden on regulated entities, comply with a court order, remove outdated requirements, and make changes identified in a five-year-review report. This rulemaking conforms to requirements in A.R.S. § 41-1027(A)(1), (3), (5), (6), and (7).

3. **Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:**  
Part of the rulemaking for 9 A.A.C. 17, Articles 1-3 relates to a five-year-review report approved by the Council on July 7, 2021.

4. **A list of all items enclosed:**  
a. Notice of Final Expedited Rulemaking, including the Preamble, Table of Contents, and text of the rule  
b. Statutory authority  
c. Current rule  
d. Laws 2021, Ch. 439

The Department is requesting that the rules be heard at the Council meeting on September 7, 2022.
I certify that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on in its evaluation of or justification for the rule.

The Department’s point of contact for questions about the rulemaking documents is Ruthann Smejkal at Ruthann.Smejkal@azdhs.gov.

Sincerely,

[Signature]

Robert Lane
Director's Designee

RL:rms

Enclosures
NOTICE OF FINAL EXPEDITED RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 17. DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

PREAMBLE

1. Article, Part or Sections Affected (as applicable) | Rulemaking Action
---|---
R9-17-101 | Amend
R9-17-102 | Amend
R9-17-103 | Amend
R9-17-107 | Amend
Table 1.1 | Amend
R9-17-202 | Amend
R9-17-203 | Amend
R9-17-204 | Amend
R9-17-303 | Amend
R9-17-304 | Amend
R9-17-305 | Amend
R9-17-306 | Amend
R9-17-307 | Amend
R9-17-308 | Amend
R9-17-310 | Amend
R9-17-311 | Amend
R9-17-312 | Amend
R9-17-316 | Amend
R9-17-317.01 | Amend
Table 3.1 | Amend
R9-17-319 | Amend
R9-17-322 | Amend
R9-17-323 | Amend
R9-17-324 | Amend

2. Citations to the agency’s statutory authority for the rulemaking to include the authorizing statute (general) and the implementing statute (specific):
Authorizing Statutes: A.R.S. §§ 36-132(A)(1) and 36-136(G)
Implementing Statutes: A.R.S. §§ 36-2803, 36-2803.01, 36-2804, 36-2804.01, 36-2806, and 36-2819

3. **The effective date of the rules:**
The rule is effective the day the Notice of Final Expedited Rulemaking is filed with the Office of the Secretary of State.

4. **Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed expedited rulemaking:**
   - Notice of Docket Opening: 28 A.A.R. 1073, May 20, 2022
   - Notice of Proposed Expedited Rulemaking: 28 A.A.R. 1414, June 17, 2022

5. **The agency’s contact person who can answer questions about the rulemaking:**
   - Name: Megan Whitby, Bureau Chief
   - Address: Department of Health Services
     Public Health Licensing Services
     150 N. 18th Ave., Suite 400
     Phoenix, AZ  85007
   - Telephone: (602) 364-3052
   - Fax: (602) 364-2079
   - E-mail: Megan.Whitby@azdhs.gov
   - or
   - Name: Stephanie Elzenga, Interim Chief
   - Address: Arizona Department of Health Services
     Office of Administrative Counsel and Rules
     150 N. 18th Ave., Suite 200
     Phoenix, AZ  85007
   - Telephone: (602) 542-1020
   - Fax: (602) 364-1150
   - E-mail: Stephanie.Elzenga@azdhs.gov

6. **An agency's justification and reason why a rule should be made, amended, repealed or renumbered, under A.R.S. § 41-1027, to include an explanation about the rulemaking:**
   Arizona Revised Statutes (A.R.S.) Title 36, Chapter 28.1, specifies requirements for the regulation of medical marijuana dispensaries and dispensary agents, as well as for qualifying patients and designated caregivers. The Arizona Department of Health Services (Department) has adopted rules to implement these statutes in Arizona Administrative Code (A.A.C.) Title 9, Chapter 17. Laws 2021, Ch. 439, made changes to the requirements for medical marijuana dispensaries and others regulated under 9 A.A.C. 17. These include allowing an individual to provide a level 1 fingerprint clearance card, issued according to A.R.S. § 41-1758.07, rather than submitting fingerprints for a background check; making changes to
medical marijuana testing requirements; requiring the addition of a time frame for testing; and allowing marijuana facility agents to work in dispensaries. In addition, the Department was ordered in Maricopa County Superior Court (Case No. CV2021-003384), to accept applications for nonprofit medical marijuana registration certificates by December 31, 2022. The rules in 9 A.A.C. 17 do not currently allow for this. After obtaining an exception from the Governor’s rulemaking moratorium established under Executive Order 2022-01, the Department is making changes to the rules in 9 A.A.C. 17 to be consistent with the court decision and/or litigation related to the rules; improve the effectiveness of the rules and make them less burdensome, including addressing inconsistencies with requirements in 9 A.A.C. 18; amend rules made obsolete by recent changes in statutory authority; correct cross-references; address issues identified in a five-year-review report approved by the Governor’s Regulatory Review Council on July 7, 2021; reduce the burden on stakeholders by eliminating or consolidating steps, procedures or processes; amend rules that are outdated, redundant, or otherwise no longer necessary; and make the rules clearer, more concise, and more understandable. Given the time constraints imposed by the court order, the Department is conducting this rulemaking in an iterative fashion, with the first including changes that will not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated, but reduce a burden due to outdated requirements without compromising health and safety. These include removing the refund of a portion of an application fee for a dispensary for applicants with complete and compliant applications that are not allocated a dispensary registration certificate, but reducing the application fee by a corresponding amount. This will reduce the economic burden on all applicants, as well as the Department.

7. A reference to any study relevant to the rules 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 Department did not review or rely on any study for this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state.
Not applicable

9. A summary of the economic, small business, and consumer impact:
Under A.R.S. § 41-1055(D)(2), the Department is not required to provide an economic, small business, and consumer impact statement.

10. A description of any changes between the proposed expedited rulemaking, including supplemental notices, and the final expedited rulemaking:
Between the proposed expedited rulemaking and the final expedited rulemaking, no changes were made to the rulemaking.
11. **Agency's summary of the public or stakeholder comments or objections made about the rulemaking and the agency response to the comments:**

The Department did not receive public or stakeholder comments about the rulemaking. However, the Department did receive a question from a stakeholder about the rules. The stakeholder asked what would happen to the other applications for one designated site for which there are multiple applications, if that site is drawn for a license. The Department does not draw a site for a license; a dispensary registration certificate application is selected for allocation of a dispensary registration certificate. According to R9-17-303(C)(2), the Department would randomly select one dispensary registration certificate application for allocation of a dispensary registration certificate to that applicant if two or more dispensary registration certificate applications specify the same location. The Department does not plan to make a change to the rules based on the question.

12. **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:**

   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:**
   
   A registration certificate for a dispensary, issued according to A.R.S. § 36-2804, or laboratory, issued according to A.R.S. § 36-2804.07, is specific to the certificate holder, type of facility, facility location, and scope of services provided. As such, a general permit is not applicable and is not used. Except when associated with authorization for the cultivation of marijuana, a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent is a general permit.

   b. **Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:**
   
   Not applicable

   c. **Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness of business in this state to the impact on business in other states:**
   
   No such analysis was submitted.

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

   Although not changed in this rulemaking, the following incorporation by reference is included in the rulemaking:

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

The rule was not previously made as an emergency rule.

15. **The full text of the rules follows:**
ARTICLE 1. GENERAL

Section
R9-17-101. Definitions
R9-17-102. Fees
R9-17-103. Application Submission Repealed
R9-17-107. Time-frames

Table 1.1 Time-frames

ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

Section
R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver
R9-17-203. Amending a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card
R9-17-204. Renewing a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card

ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS

Section
R9-17-303. Dispensary Registration Certificate Allocation Process
R9-17-304. Applying for a Dispensary Registration Certificate
R9-17-305. Applying for Approval to Operate a Dispensary
R9-17-306. Changes to a Dispensary Registration Certificate
R9-17-307. Applying to Change a Dispensary’s Location or Change or Add a Dispensary’s Cultivation Site Dispensary Registration Certificate
R9-17-308. Renewing a Dispensary Registration Certificate
R9-17-310. Administration
R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card
R9-17-312. Submitting an Application to Renew a Dispensary Agent’s Registry Identification Card
R9-17-316. Inventory Control System
R9-17-317.01. Analysis of Medical Marijuana or a Marijuana Product

Table 3.1. Analytes
R9-17-319. Edible Food Products
R9-17-322. Denial or Revocation of a Dispensary Registration Certificate
R9-17-323. Denial or Revocation of a Dispensary Agent’s Registry Identification Card
R9-17-324. Dual Licensees
ARTICLE 1. GENERAL

R9-17-101. Definitions
In addition to the definitions in A.R.S. § 36-2801, the following definitions apply in this Chapter unless otherwise stated:

1. “Accreditation” means being deemed as technically competent under ISO 17025 by the:
   a. American Association of Laboratory Accreditation,
   b. Perry Johnson Laboratory Accreditation,
   c. ANSI National Accreditation Board, or
   d. International Accreditation Services.
2. “Accuracy testing” means a mechanism in which a laboratory performs testing on samples with known characteristics, prepared by the laboratory, to determine a laboratory agent’s ability to analyze samples within specific acceptance criteria.
3. “Acquire” means to obtain through any type of transaction and from any source.
4. “Activities of daily living” means ambulating, bathing, dressing, grooming, eating, toileting, and getting in and out of bed.
5. “Amend” means adding or deleting information on an individual’s registry identification card that affects the individual’s ability to perform or delegate a specific act or function.
6. “Analyte” means a specific substance for which testing is performed by a laboratory.
7. “Applicant” means:
   a. An individual submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent;
   b. An entity submitting an application for a dispensary registration certificate or approval to operate a dispensary; or
   c. An individual or entity submitting an application for a laboratory registration certificate, approval to test, or approval to change parameters.
8. “Batch” means:
   a. When referring to cultivated medical marijuana, a specific lot of medical marijuana grown from one or more seeds or cuttings that are planted and harvested at the same time;
   b. When referring to marijuana products, a specific amount of a marijuana product infused, manufactured, or prepared for sale from the same set of ingredients at the same time; and
   c. When referring to testing of medical marijuana or a marijuana product, a specific set of samples prepared and tested during the same run using the same equipment.
9. “Batch number” means a unique numeric or alphanumeric identifier assigned to a batch by a dispensary when:
a. The batch of medical marijuana is planted, or  
b. The batch of a marijuana product is infused, manufactured, or prepared for sale.

10. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

11. “Change” means:
   a. When used in relation to a registry identification card, adding or deleting information on an individual’s registry identification card that does not substantively affect the individual’s ability to perform or delegate a specific act or function;
   b. When used in relation to a place, moving to a different location;
   c. When used in relation to an individual, selecting a different individual to perform specific actions;
   d. When used in relation to parameters, revising a laboratory’s standard operating procedures or quality assurance plan, required in R9-17-404.06, due to:
      i. Adding or removing a parameter,
      ii. Altering a testing method, or
      iii. Using a different instrument for performing a test; and
   e. When used in relation to testing results, altering the testing results in any way and for any reason.

12. “Commercial device” means the same as in A.R.S. § 3-3451.

13. “Contaminant” means matter, pollutant, hazardous substance, or other substance that is not intended to be part of dispensed medical marijuana or a marijuana product.

14. “Cultivation site” means the one additional location where marijuana may be cultivated, infused, or prepared for sale by and for a dispensary.

15. “Current photograph” means an image of an individual, taken no more than 60 calendar days before the submission of the individual’s application, in a Department-approved electronic format capable of producing an image that:
   a. Has a resolution of at least 600 x 600 pixels but not more than 1200 x 1200 pixels;
   b. Is 2 inches by 2 inches in size;
   c. Is in natural color;
   d. Is a front view of the individual’s full face, without a hat or headgear that obscures the hair or hairline;
   e. Has a plain white or off-white background; and
   f. Has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head.
16. “Denial” means the Department’s final decision not to issue a registry identification card, a dispensary registration certificate, a laboratory registration certificate, or an approval of a change of dispensary or a dispensary’s cultivation site location, to an applicant because the applicant or the application does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.

17. “Dispensary” means the same as “nonprofit medical marijuana dispensary” as defined in A.R.S. § 36-2801.

18. “Dispensary agent” means the same as “nonprofit medical marijuana dispensary agent” as defined in A.R.S. § 36-2801.


20. “Edible food product” means a substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human oral consumption.

21. “Enclosed area” when used in conjunction with “enclosed, locked facility” means outdoor space surrounded by solid, 10-foot walls, constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, and a 1-inch thick metal gate.

22. “Entity” means the same as in A.R.S. § 29-2102.

23. “Generally accepted accounting principles” means the set of financial reporting standards established by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or another specialized body dealing with accounting and auditing matters.

24. “Geographic area” means the same as in A.R.S. § 36-2803.01.


26. “Inhalable” means intended for use through intake into the lungs of an individual.

27. “Laboratory” means the same as “independent third-party laboratory” as defined in A.R.S. § 36-2801.

28. “Laboratory agent” means the same as “independent third-party laboratory agent” as defined in A.R.S. § 36-2801.

29. “Legal guardian” means an adult who is responsible for a minor:
   a. Through acceptance of guardianship of the minor through a testamentary appointment or an appointment by a court pursuant to A.R.S. Title 14, Chapter 5, Article 2; or
   b. As a “custodian” as defined in A.R.S. § 8-201.

30. “Marijuana establishment” means the same as in A.R.S. § 36-2850.

31. “Marijuana facility agent” means the same as in A.R.S. § 36-2850.

32. “Medical record” means the same as:
   a. “Adequate records” as defined in A.R.S. § 32-1401,
   b. “Adequate medical records” as defined in A.R.S. § 32-1501,
c. “Adequate records” as defined in A.R.S. § 32-1800, or
d. “Adequate records” as defined in A.R.S. § 32-2901.


33.34. “Parameter” means the combination of a particular type of sample with a specific instrument or equipment by which the sample will be tested for a specific analyte or characteristic.

34.35. “Proficiency testing” means a mechanism in which samples with known characteristics are submitted to a laboratory for analysis to determine a laboratory agent’s ability to analyze samples within specific acceptance criteria.

35.36. “Proficiency testing service” means an independent company or other person acceptable to the Department, based on ISO/IEC 17043:2010 certification, that:

a. Is the source for samples with known characteristics for proficiency testing, and
b. Assesses the acceptability of a laboratory agent’s results from the samples with known characteristics during proficiency testing.


37. “Public place”:

a. Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or a specific group of individuals;

b. Includes, but not is limited to:
   i. Airports;
   ii. Banks;
   iii. Bars;
   iv. Child care facilities;
   v. Child care group homes during hours of operation;
   vi. Common areas of apartment buildings, condominiums, or other multifamily housing facilities;
   vii. Educational facilities;
   viii. Entertainment facilities or venues;
   ix. Health care institutions, except as provided in subsection (24)(c);
   x. Hotel and motel common areas;
   xi. Laundromats;
   xii. Libraries;
   xiii. Office buildings;
   xiv. Parking lots;
   xv. Parks;
   xvi. Public transportation facilities;
xvii. Reception areas;
xviii. Restaurants;
xix. Retail food production or marketing establishments;
xx. Retail service establishments;
xxi. Retail stores;
xxii. Shopping malls;
xxiii. Sidewalks;
xxiv. Sports facilities;
xxv. Theaters; and
xxvi. Waiting rooms; and
e. Does not include:
i. Nursing care institutions as defined in A.R.S. § 36-401,
ii. Hospices as defined in A.R.S. § 36-401,
iii. Assisted living centers as defined in A.R.S. § 36-401,
iv. Assisted living homes as defined in A.R.S. § 36-401,
v. Adult day health care facilities as defined in A.R.S. § 36-401,
vi. Adult foster care homes as defined in A.R.S. § 36-401, or
vii. Private residences.

38. “Public school” means the same as “school” as defined in A.R.S. § 15-101.

39. “Registry identification number” means the random 20-digit alphanumeric identifier generated by the Department, containing at least four numbers and four letters, issued by the Department to a qualifying patient, designated caregiver, dispensary, dispensary agent, laboratory, or laboratory agent.

40. “Revocation” means the Department’s final decision that an individual’s registry identification card, a dispensary registration certificate, or a laboratory registration certificate is rescinded because the individual, the dispensary, or the laboratory does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.

41. “Sample” means:
a. A representative portion of a larger quantity of medical marijuana or a marijuana product,
b. A specific quantity of a substance or set of substances to be used for testing purposes, or
c. To collect the representative portion in subsection (39)(a).


42-43. “Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state
holiday or a statewide furlough day.

**R9-17-102. Fees**

A. An applicant submitting an application to the Department shall submit the following nonrefundable fees:

1. Except as provided in R9-17-303(D), for registration of a dispensary, $5,000 $4,000;
2. To renew the registration of a dispensary, $1,000;
3. To change the location of a dispensary, $2,500;
4. To change the location of a dispensary’s cultivation site or add a cultivation site, $2,500;
5. For a registry identification card for a:
   a. Qualifying patient, except as provided in subsection (B), $150;
   b. Designated caregiver, $200;
   c. Dispensary agent, $500; and
   d. Laboratory agent, $500;
6. For renewing a registry identification card for a:
   a. Qualifying patient, except as provided in subsection (B), $150;
   b. Designated caregiver, $200;
   c. Dispensary agent, $500; and
   d. Laboratory agent, $500;
7. For amending or changing a registry identification card, $10;
8. For requesting a replacement registry identification card, $10;
9. For registration of a laboratory, $5,000; and
10. To renew the registration of a laboratory, $1,000.

B. A qualifying patient may pay a reduced fee of $75 if the qualifying patient submits, with the qualifying patient’s application for a registry identification card or the qualifying patient’s application to renew the qualifying patient’s registry identification card, a copy of an eligibility notice or electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture, Food and Nutrition Services, Supplemental Nutrition Assistance Program.

**R9-17-103. Application Submission Repealed**

A. An applicant submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent, shall submit the application electronically in a Department-provided format.

B. A residence address or mailing address submitted for a qualifying patient or designated caregiver as part of an application for a registry identification card is located in Arizona.

C. A mailing address submitted for a principal officer or board member as part of a dispensary certificate registration application or as part of an application for a dispensary agent registration identification card is located in Arizona.
D. A mailing address submitted for an owner as a part of a laboratory registration certificate application or as part of an application for a laboratory agent registration identification card is located in Arizona.

R9-17-107. Time-frames

A. Within the administrative completeness review time-frame for each type of approval in Table 1.1, the Department shall:

1. Issue a registry identification card, a dispensary registration certificate, an approval to operate a dispensary, a laboratory registration certificate, an approval for testing, or an approval to add a parameter;
2. Provide a notice of administrative completeness to an applicant; or
3. Provide a notice of deficiencies to an applicant, including a list of the information or documents needed to complete the application.

B. An application for approval to operate a dispensary is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-305 that the dispensary is ready for an inspection by the Department.

C. A laboratory’s application for approval for testing is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-402.01 that the laboratory is ready for an inspection by the Department.

D. If the Department provides a notice of deficiencies to an applicant:

1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant; and
2. The Department shall consider the application withdrawn if the applicant does not submit the missing information or documents to the Department within the time-frame in Table 1.1.

E. Within the substantive review time-frame for each type of approval in Table 1.1, the Department:

1. According to subsection (H), shall issue or deny:
   a. A registry identification card, dispensary registration certificate, or laboratory registration certificate; or
   b. Approval to operate a dispensary, approval for testing, or approval to add a parameter;
2. May complete an inspection that may require more than one visit to a dispensary and, if applicable, the dispensary’s cultivation site;
3. May complete an inspection that may require more than one visit to a laboratory; and
4. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.

F. If the Department issues a written comprehensive request or a supplemental request for information:
1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives all of the information requested, and

2. The applicant shall submit to the Department all of the information and documents listed in the written comprehensive request or supplemental request for information within 40 working days after the date of the comprehensive written request or supplemental request for information the time-frame in Table 1.1.

G.

If an applicant for an initial dispensary registration certificate is allocated a dispensary registration certificate as provided in R9-17-303, the Department shall provide a written notice to the applicant of the allocation of the dispensary registration certificate that contains the dispensary’s registry identification number and issue the dispensary registration certificate.

1. After the applicant receives the written notice of the allocation, the applicant shall submit to the Department for each principal officer or board member for whom fingerprints were submitted according to R9-17-304(C)(3)(b):

   a. An application for a dispensary agent registry identification card that includes:
      i. The principal officer’s or board member’s first name; middle initial, if applicable; last name; and suffix, if applicable;
      ii. The principal officer’s or board member’s residence address and mailing address;
      iii. The county where the principal officer or board member resides;
      iv. The principal officer’s or board member’s date of birth;
      v. The identifying number on the applicable card or document in subsection (G)(1)(b)(i) through (v);
      vi. The name and registry identification number of the dispensary;
      vii. One of the following:
         (1) A statement that the principal officer or board member does not currently hold a valid registry identification card, or
         (2) The assigned registry identification number for each valid registry identification card currently held by the principal officer or board member;
      viii. A statement signed by the principal officer or board member pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
      ix. An attestation that the information provided in and with the application is true and correct; and
      x. The signature of the principal officer or board member and the date the principal
officer or board member signed;

b. A copy the principal officer’s or board member’s:
   i. Arizona driver’s license issued on or after October 1, 1996;
   ii. Arizona identification card issued on or after October 1, 1996;
   iii. Arizona registry identification card;
   iv. Photograph page in the principal officer’s or board member’s U.S. passport; or
   v. Arizona driver’s license or identification card issued before October 1, 1996 and
      one of the following for the principal officer or board member:
         (1) Birth certificate verifying U.S. citizenship,
         (2) U.S. Certificate of Naturalization, or
         (3) U.S. Certificate of Citizenship;

c. A current photograph of the principal officer or board member; and

d. The applicable fee in R9-17-102 for applying for a dispensary agent registry
   identification card.

2. After receipt of the information and documents in subsection (G)(1), the Department shall review
   the information and documents.
   a. If the information and documents for at least one of the principal officers or board
      members complies with the A.R.S. Title 36, Chapter 28.1 and this Chapter, the
      Department shall issue:
         i. A dispensary agent registry identification card to any principal officer or board
            member whose dispensary agent registry identification card application complies
            with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
         ii. The dispensary registration certificate.
   b. If the information and documents for a dispensary agent registry identification card
      application for any principal officer or board member does not comply with A.R.S. Title
      36, Chapter 28.1 and this Chapter, the Department shall deny the dispensary agent
      registry identification card application and provide notice to the principal officer or board
      member and to the dispensary that includes:
         i. The specific reasons for the denial; and
         ii. The process for requesting a judicial review of the Department’s decision
            pursuant to A.R.S. Title 12, Chapter 7, Article 6.

H. If an application for an initial laboratory registration certificate is approved, the Department shall review
   the information and documents submitted according to R9-17-402(A)(4) and:
   1. If the information and documents for at least one of the owners comply with the A.R.S. Title 36,
      Chapter 28.1 and this Chapter, the Department shall issue:
a. A laboratory agent registry identification card to any owner who complies with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
b. The laboratory registration certificate; and

d. If the information and documents submitted according to R9-17-402(A)(4) for an owner do not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall deny the owner a laboratory agent registry identification card and provide notice to the owner and to the laboratory that includes:
a. The specific reasons for the denial; and
b. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

I. The Department shall issue:

1. A registry identification card, renewal of a dispensary registration certificate, an approval to operate a dispensary, renewal of a laboratory registration certificate, an approval for testing, or an approval to add a parameter, as applicable, if the Department determines that the applicant complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;

2. For an applicant for a registry identification card, a denial that includes the reason for the denial and the process for requesting judicial review if:
a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter; or
b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information;

3. For an applicant for an initial dispensary registration certificate, if the Department determines that the dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter:
a. A dispensary registration certificate, if not all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; or
b. Written notice that:
   i. The dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
   ii. The applicant was not allocated a dispensary registration certificate according to the criteria and processes in R9-17-303 because all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; and
iii. The written notice is not a denial and is not considered a final decision of the Department subject to administrative review; or

4. For an applicant for a dispensary registration certificate, an approval to operate, a laboratory registration certificate, an approval for testing, or an approval to add a parameter, a denial that includes the reason for the denial and the process for administrative review if:
   a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
   b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
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<th>Type of Approval</th>
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ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver

A. Except for a qualifying patient who is under 18 years of age, a qualifying patient is not required to have a designated caregiver.

B. A qualifying patient may have only one designated caregiver at any given time.

C. Except for a qualifying patient who is under 18 years of age, if the information submitted for a qualifying patient complies with A.R.S. Title 36, Chapter 28.1 and this Chapter but the information for the qualifying patient’s designated caregiver does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue the registry identification card for the qualifying patient separate from issuing a registry identification card for the qualifying patient’s designated caregiver.

D. If the Department issues a registry identification card to a qualifying patient under subsection (C), the Department shall continue the process for issuing or denying the qualifying patient’s designated caregiver’s registry identification card.

E. The Department shall not issue a designated caregiver’s registry identification card before the Department issues the designated caregiver’s qualifying patient’s registry identification card.

F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s:
      i. First name; middle initial, if applicable; last name; and suffix, if applicable;
      ii. Date of birth; and
      iii. Gender;
   b. Except as provided in subsection (F)(1)(i), the qualifying patient’s Arizona residence address and Arizona mailing address;
   c. The county where the qualifying patient resides;
   d. The qualifying patient’s e-mail address;
   e. The identifying number on the applicable card or document in subsection (F)(2)(a) through (e);
   f. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;
g. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;

h. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;

i. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;

j. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;

k. An attestation that the information provided in the application is true and correct; and

l. The signature of the qualifying patient and date the qualifying patient signed;

2. A copy of the qualifying patient’s:

   a. Arizona driver’s license issued on or after October 1, 1996;
   b. Arizona identification card issued on or after October 1, 1996;
   c. Arizona registry identification card;
   d. Photograph page in the qualifying patient’s U.S. passport or a U.S. passport card; or
   e. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the qualifying patient:
      i. Birth certificate verifying U.S. citizenship,
      ii. U.S. Certificate of Naturalization, or
      iii. U.S. Certificate of Citizenship;

3. A current photograph of the qualifying patient;

4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A physician’s written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s application that includes:

   a. The physician’s:
      i. Name,
ii. License number including an identification of the physician license type,
iii. Office address on file with the physician’s licensing board,
iv. Telephone number on file with the physician’s licensing board, and
v. E-mail address;

b. The qualifying patient’s name and date of birth;
c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
d. An identification, initialed by the physician, of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;
e. If the debilitating medical condition identified in subsection (F)(5)(d) is a condition in:
i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
ii. R9-17-201(14), the debilitating medical condition;
f. A statement, initialed by the physician, that the physician:
i. Has established a medical record for the qualifying patient, and
ii. Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;
h. The date the physician conducted the in-person physical examination of the qualifying patient;
i. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
i. Medical records including medical records from other treating physicians from the previous 12 months,
ii. Response to conventional medications and medical therapies, and
iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;

k. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;

l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;

m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:

i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and

ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;

n. An attestation that the information provided in the written certification is true and correct; and

o. The physician’s signature and the date the physician signed;

6. If the qualifying patient is designating a caregiver, the following in a Department-provided format:

a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;

b. The designated caregiver’s date of birth;

c. The designated caregiver’s Arizona residence address and Arizona mailing address;

d. The county where the designated caregiver resides;

e. The identifying number on the applicable card or document in subsection (F)(6)(i)(i) through (v);

f. One of the following:

i. A statement that the designated caregiver does not currently hold a valid
registry identification card, or

ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

g.f. An attestation signed and dated by the designated caregiver that the designated caregiver:

i. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or

ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

h.g. A statement signed by the designated caregiver:

i. Agreeing to assist the qualifying patient with the medical use of marijuana; and

ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

i.h. A copy of the designated caregiver’s:

i. Arizona driver’s license issued on or after October 1, 1996;

ii. Arizona identification card issued on or after October 1, 1996;

iii. Arizona registry identification card;

iv. Photograph page in the designated caregiver’s U.S. passport or a U.S. passport card; or

v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:

(1) Birth certificate verifying U.S. citizenship,

(2) U.S. Certificate of Naturalization, or

(3) U.S. Certificate of Citizenship;

j.i. A current photograph of the designated caregiver; and

k.j. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:

i. The designated caregiver’s fingerprints on a fingerprint card that includes:

(1) The designated caregiver’s first name; middle initial, if applicable; and last name;
(2) The designated caregiver’s signature;
(3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
(4) The designated caregiver’s address;
(5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
(6) The designated caregiver’s date of birth;
(7) The designated caregiver’s Social Security number;
(8) The designated caregiver’s citizenship status;
(9) The designated caregiver’s gender;
(10) The designated caregiver’s race;
(11) The designated caregiver’s height;
(12) The designated caregiver’s weight;
(13) The designated caregiver’s hair color;
(14) The designated caregiver’s eye color; and
(15) The designated caregiver’s place of birth; or

ii. If the designated caregiver’s fingerprints and information required in subsection (F)(6)(k)(i) (F)(6)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or

iii. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and

7. The applicable fees in R9-17-102 for applying for:
   a. A qualifying patient registry identification card; and
   b. If applicable, a designated caregiver registry identification card.

G. To apply for a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
1. An application in a Department-provided format that includes:
a. The qualifying patient’s:
   i. First name; middle initial, if applicable; last name; and suffix, if applicable;
   ii. Date of birth; and
   iii. Gender;

b. The qualifying patient’s Arizona residence address and Arizona mailing address;

c. The county where the qualifying patient resides;

d. The qualifying patient’s custodial parent’s or legal guardian’s first name; middle initial, if applicable; last name; and suffix, if applicable;

e. The identifying number on the applicable card or document in subsection (G)(5)(a) through (e);

f. The qualifying patient’s custodial parent’s or legal guardian’s Arizona residence address and Arizona mailing address;

g. The county where the qualifying patient’s custodial parent or legal guardian resides;

h. The qualifying patient’s custodial parent’s or legal guardian’s e-mail address;

i. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;

j. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the patient’s medical record, maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;

k. The qualifying patient’s custodial parent’s or legal guardian’s date of birth;

l. Whether the qualifying patient’s custodial parent or legal guardian is requesting authorization for cultivating medical marijuana plants for the qualifying patient’s medical use because the qualifying patient’s custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;

m. Whether the qualifying patient’s custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;

n. Whether the individual submitting the application on behalf of the qualifying patient under 18 years of age is the qualifying patient’s custodial parent or legal
guardian;

0. One of the following:
   i. A statement that the qualifying patient’s custodial parent or legal guardian does not currently hold a valid registry identification card, or
   ii. The assigned registry identification number for the qualifying patient’s custodial parent or legal guardian for each valid registry identification card currently held by the qualifying patient’s custodial parent or legal guardian;

p-o. An attestation that the information provided in the application is true and correct; and

q-p. The signature of the qualifying patient’s custodial parent or legal guardian and the date the qualifying patient’s custodial parent or legal guardian signed;

2. A current photograph of the:
   a. Qualifying patient, and
   b. Qualifying patient’s custodial parent or legal guardian serving as the qualifying patient’s designated caregiver;

3. An attestation in a Department-provided format signed and dated by the qualifying patient’s custodial parent or legal guardian that the qualifying patient’s custodial parent or legal guardian:
   a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
   b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

4. A statement in a Department-provided format signed by the qualifying patient’s custodial parent or legal guardian who is serving as the qualifying patient’s designated caregiver:
   a. Allowing the qualifying patient’s medical use of marijuana;
   b. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   c. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A copy of one of the following for the qualifying patient’s custodial parent or legal guardian:
   a. Arizona driver’s license issued on or after October 1, 1996;
   b. Arizona identification card issued on or after October 1, 1996;
c. Arizona registry identification card;
d. Photograph page in the qualifying patient’s custodial parent or legal guardian
   U.S. passport or a U.S. passport card; or
e. Arizona driver’s license or identification card issued before October 1, 1996 and
   one of the following for the qualifying patient’s custodial parent or legal
   guardian:
   i. Birth certificate verifying U.S. citizenship,
   ii. U. S. Certificate of Naturalization, or
   iii. U. S. Certificate of Citizenship;

6. If the individual submitting the application on behalf of a qualifying patient is the
   qualifying patient’s legal guardian, a copy of documentation establishing the individual
   as the qualifying patient’s legal guardian;

7. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
a. The qualifying patient’s custodial parent or legal guardian’s fingerprints on a
   fingerprint card that includes:
   i. The qualifying patient’s custodial parent or legal guardian’s first name;
      middle initial, if applicable; and last name;
   ii. The qualifying patient’s custodial parent or legal guardian’s signature;
   iii. If different from the qualifying patient’s custodial parent or legal
       guardian, the signature of the individual physically rolling the qualifying
       patient’s custodial parent’s or legal guardian’s fingerprints;
   iv. The qualifying patient’s custodial parent’s or legal guardian’s address;
   v. If applicable, the qualifying patient’s custodial parent’s or legal
      guardian’s surname before marriage and any names previously used by
      the qualifying patient’s custodial parent or legal guardian;
   vi. The qualifying patient’s custodial parent’s or legal guardian’s date of
       birth;
   vii. The qualifying patient’s custodial parent’s or legal guardian’s Social
        Security number;
   viii. The qualifying patient’s custodial parent’s or legal guardian’s citizenship
        status;
   ix. The qualifying patient’s custodial parent’s or legal guardian’s gender;
   x. The qualifying patient’s custodial parent’s or legal guardian’s race;
   xi. The qualifying patient’s custodial parent’s or legal guardian’s height;
xii. The qualifying patient’s custodial parent’s or legal guardian’s weight;

xiii. The qualifying patient’s custodial parent’s or legal guardian’s hair color;

xiv. The qualifying patient’s custodial parent’s or legal guardian’s eye color;

and

xv. The qualifying patient’s custodial parent’s or legal guardian’s place of birth; or

b. If the qualifying patient’s custodial parent’s or legal guardian’s fingerprints and information required in subsection (G)(7)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the qualifying patient’s custodial parent or legal guardian as a result of the application; or

c. Documentation that the qualifying patient’s custodial parent or legal guardian has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

8. A written certification from the physician in subsection (G)(1)(i) and a separate written certification from the physician in (G)(1)(j) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s application that includes:

a. The physician’s:

i. Name,

ii. License number including an identification of the physician license type,

iii. Office address on file with the physician’s licensing board,

iv. Telephone number on file with the physician’s licensing board, and

v. E-mail address;

b. The qualifying patient’s name and date of birth;

c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;

d. If the debilitating medical condition identified in subsection (G)(9)(c) is a condition in:

i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or

ii. R9-17-201(14), the debilitating medical condition;
e. For the physician listed in subsection (G)(1)(i):

i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;

ii. A statement, initialed by the physician, that the physician:
   (1) Has established a medical record for the qualifying patient, and
   (2) Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;

iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;

iv. The date the physician conducted the in-person physical examination of the qualifying patient;

v. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   (1) Medical records, including medical records from other treating physicians from the previous 12 months,
   (2) Response to conventional medications and medical therapies, and
   (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient; and

vii. A statement, initialed by the physician, that the physician has provided information to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient, if the qualifying patient is female, that warns about:
   (1) The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
   (2) The risk of being reported to the Department of Child Safety
during pregnancy or at the birth of the child by persons who are required to report;

f. For the physician listed in subsection (G)(1)(j), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient’s medical records from other treating physicians;

g. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;

h. A statement, initialed by the physician, that, if the physician has referred the qualifying patient’s custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;

i. An attestation that the information provided in the written certification is true and correct; and

j. The physician’s signature and the date the physician signed; and

9. The applicable fees in R9-17-102 for applying for a:
   a. Qualifying patient registry identification card, and
   b. Designated caregiver registry identification card.

H. For purposes of this Article, “25 miles” includes the area contained within a circle that extends for 25 miles in all directions from a specific location.

I. For purposes of this Article, “residence address” when used in conjunction with a qualifying patient means:
   1. The street address including town or city and zip code assigned by a local jurisdiction; or
   2. For property that does not have a street address assigned by a local jurisdiction, the legal description of the property on the title documents recorded by the assessor of the county in which the property is located.

R9-17-203. Amending a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card

A. To add a designated caregiver or to request a change of a qualifying patient’s designated caregiver, the qualifying patient shall submit to the Department, within 10 working days after the addition or the change, the following:
   1. An application in a Department-provided format that includes:
      a. The qualifying patient’s name and the registry identification number on the
qualifying patient’s current registry identification card;

b. If applicable, the name of the qualifying patient’s current designated caregiver and the date the designated caregiver last provided or will last provide assistance to the qualifying patient;

c. The name of the individual the qualifying patient is designating as caregiver; and

d. The signature of the qualifying patient and date the qualifying patient signed;

2. For the caregiver the qualifying patient is designating:

a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;

b. The designated caregiver’s date of birth;

c. The designated caregiver’s Arizona residence address and Arizona mailing address;

d. The county where the designated caregiver resides;

e. The identifying number on the applicable card or document in subsection (A)(2)(i)(i) (A)(2)(h)(i) through (v);

f. One of the following:

i. A statement that the designated caregiver does not currently hold a valid registry identification card, or

ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

g. An attestation in a Department-provided format signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

h. A statement in a Department-provided format signed by the designated caregiver:

i. Agreeing to assist the qualifying patient with the medical use of marijuana; and

ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

i. A copy the designated caregiver’s:

i. Arizona driver’s license issued on or after October 1, 1996;

ii. Arizona identification card issued on or after October 1, 1996;

iii. Arizona registry identification card;
iv. Photograph page in the designated caregiver’s U.S. passport or a U.S. passport card; or

v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
   (1) Birth certificate verifying U.S. citizenship,
   (2) U. S. Certificate of Naturalization, or
   (3) U. S. Certificate of Citizenship;

j.i. A current photograph of the designated caregiver; and

k.i. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   i. The designated caregiver’s fingerprints on a fingerprint card that includes:
      (1) The designated caregiver’s first name; middle initial, if applicable; and last name;
      (2) The designated caregiver’s signature;
      (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
      (4) The designated caregiver’s address;
      (5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
      (6) The designated caregiver’s date of birth;
      (7) The designated caregiver’s Social Security number;
      (8) The designated caregiver’s citizenship status;
      (9) The designated caregiver’s gender;
      (10) The designated caregiver’s race;
      (11) The designated caregiver’s height;
      (12) The designated caregiver’s weight;
      (13) The designated caregiver’s hair color;
      (14) The designated caregiver’s eye color; and
      (15) The designated caregiver’s place of birth; or

ii. If the designated caregiver’s fingerprints and information required in subsection (A)(2)(k)(i) (A)(2)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification
card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and

3. The applicable fee in R9-17-102 for applying for a designated caregiver registry identification card.

B. To amend a qualifying patient’s address on the qualifying patient’s registry identification card when the qualifying patient or the qualifying patient’s designated caregiver is authorized to cultivate marijuana, the qualifying patient shall submit to the Department, within 10 working days after the change in address, the following:

1. The qualifying patient’s name and the registry identification number on the qualifying patient’s current registry identification card;
2. The qualifying patient’s new address;
3. The county where the new address is located;
4. The name of the qualifying patient’s designated caregiver, if applicable;
5. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
6. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;
7. The effective date of the qualifying patient’s new address; and
8. The applicable fee in R9-17-102 for applying to:
   a. Amend a qualifying patient’s registry identification card; and
   b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver’s registry identification card.

C. To request authorization to cultivate marijuana based on a qualifying patient’s current address or a new address, the qualifying patient shall submit to the Department, if applicable within 10 working days after the change in address, the following:

1. The qualifying patient’s name and the registry identification number on the qualifying patient’s current registry identification card;
2. If the qualifying patient’s address is a new address, the qualifying patient’s:
   a. Current address,
   b. New address,
c. The county where the new address is located, and  
d. The effective date of the qualifying patient’s new address;
3. The name of the qualifying patient’s designated caregiver, if applicable;
4. Whether the qualifying patient is requesting authorization for cultivating marijuana plants  
   for the qualifying patient’s medical use because the qualifying patient believes that the  
   qualifying patient resides at least 25 miles from the nearest operating dispensary;
5. If the qualifying patient is requesting authorization for cultivating marijuana plants,  
   whether the qualifying patient is designating the qualifying patient’s designated caregiver  
   to cultivate marijuana plants for the qualifying patient’s medical use; and
6. The applicable fee in R9-17-102 for applying to:  
   a. Amend a qualifying patient’s registry identification card; and  
   b. If the qualifying patient is designating a designated caregiver for cultivation  
      authorization, amend a designated caregiver’s registry identification card.

R9-17-204. Renewing a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card
A. Except for a qualifying patient who is under 18 years of age, to renew a qualifying patient’s  
   registry identification card, the qualifying patient shall submit the following to the Department at  
   least 30 calendar days before the expiration date of the qualifying patient’s registry identification  
   card:
   1. An application in a Department-provided format that includes:  
      a. The qualifying patient’s first name; middle initial, if applicable; last name; and  
         suffix, if applicable;  
      b. The qualifying patient’s date of birth;  
      c. Except as provided in subsection (A)(1)(j), the qualifying patient’s Arizona  
         residence address and Arizona mailing address;  
      d. The county where the qualifying patient resides;  
      e. The qualifying patient’s e-mail address;  
      f. The registry identification number on the qualifying patient’s current registry  
         identification card;  
      g. The name, address, and telephone number of the physician providing the written  
         certification for medical marijuana for the qualifying patient;  
      h. Whether the qualifying patient is requesting authorization for cultivating  
         marijuana plants for the qualifying patient’s medical use because the qualifying  
         patient believes that the qualifying patient resides at least 25 miles from the
nearest operating dispensary;

i. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;

j. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;

k. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;

l. An attestation that the information provided in the application is true and correct; and

m. The signature of the qualifying patient and the date the qualifying patient signed;

2. If the qualifying patient’s name in subsection (A)(1)(a) is not the same name as on the qualifying patient’s current registry identification card, one of the following with the qualifying patient’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the qualifying patient’s U.S. passport or a U.S. passport card;

3. A current photograph of the qualifying patient;

4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A physician’s written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s renewal application that includes:
   a. The physician’s:
      i. Name,
      ii. License number including an identification of the physician license type,
      iii. Office address on file with the physician’s licensing board,
      iv. Telephone number on file with the physician’s licensing board, and
      v. E-mail address;
   b. The qualifying patient’s name and date of birth;
   c. A statement that the physician has made or confirmed a diagnosis of a
debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;

d. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;

e. If the debilitating medical condition identified in subsection (A)(5)(d) is a condition in:
   i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
   ii. R9-17-201(14), the debilitating medical condition;

f. A statement, initialed by the physician, that the physician:
   i. Has established a medical record for the qualifying patient, and
   ii. Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;

g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;

h. The date the physician conducted the in-person physical examination of the qualifying patient;

i. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   i. Medical records including medical records from other treating physicians from the previous 12 months,
   ii. Response to conventional medications and medical therapies, and
   iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;

k. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;
l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;

m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:
   i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
   ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;

n. An attestation that the information provided in the written certification is true and correct; and

o. The physician’s signature and the date the physician signed;

6. If the qualifying patient is designating a caregiver or if the qualifying patient’s designated caregiver’s registry identification card has the same expiration date as the qualifying patient’s registry identification card, the following in a Department-provided format:
   a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The designated caregiver’s date of birth;
   c. The designated caregiver’s Arizona residence address and Arizona mailing address;
   d. The county where the designated caregiver resides;
   e. If the qualifying patient is renewing the designated caregiver’s registry identification card, the registry identification number on the designated caregiver’s registry identification card associated with the qualifying patient;
   f. If the qualifying patient is designating an individual not previously designated as the qualifying patient’s designated caregiver, the identification number on and a copy of the designated caregiver’s:
      i. Arizona driver’s license issued on or after October 1, 1996;
      ii. Arizona identification card issued on or after October 1, 1996;
      iii. Arizona registry identification card;
      iv. Photograph page in the designated caregiver’s U. S. passport or a U. S. passport.
passport card; or

v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
   (1) Birth certificate verifying U.S. citizenship,
   (2) U. S. Certificate of Naturalization, or
   (3) U. S. Certificate of Citizenship;

g. If the qualifying patient is designating an individual not previously designated as the qualifying patient’s designated caregiver, one of the following:
   i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
   ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

h. A current photograph of the designated caregiver;

i. An attestation signed and dated by the designated caregiver that the designated caregiver:
   has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
   is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

j. A statement in a Department-provided format signed by the designated caregiver:
   i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and

k. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   i. The designated caregiver’s fingerprints on a fingerprint card that includes:
      (1) The designated caregiver’s first name; middle initial, if applicable; and last name;
      (2) The designated caregiver’s signature;
      (3) If different from the designated caregiver, the signature of the
individual physically rolling the designated caregiver’s fingerprints;
(4) The designated caregiver’s address;
(5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
(6) The designated caregiver’s date of birth;
(7) The designated caregiver’s Social Security number;
(8) The designated caregiver’s citizenship status;
(9) The designated caregiver’s gender;
(10) The designated caregiver’s race;
(11) The designated caregiver’s height;
(12) The designated caregiver’s weight;
(13) The designated caregiver’s hair color;
(14) The designated caregiver’s eye color; and
(15) The designated caregiver’s place of birth; or

ii. If the designated caregiver’s fingerprints and information required in subsection (A)(6)(k)(i) (A)(6)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or

iii. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

7. If the qualifying patient’s designated caregiver’s registry identification card has the same expiration date as the qualifying patient’s registry identification card and the designated caregiver’s name in subsection (A)(6)(a) is not the same name as on the designated caregiver’s current registry identification card, one of the following with the designated caregiver’s new name:

a. An Arizona driver’s license,
b. An Arizona identification card, or
c. The photograph page in the designated caregiver’s U.S. passport or a U.S. passport card; and
8. The applicable fees in R9-17-102 for applying to:
  a. Renew a qualifying patient’s registry identification card; and
  b. If applicable, issue or renew a designated caregiver’s registry identification card.

B. To renew a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s:
      i. First name; middle initial, if applicable; last name; and suffix, if applicable; and
      ii. Date of birth;
   b. The qualifying patient’s Arizona residence address and Arizona mailing address;
   c. The county where the qualifying patient resides;
   d. The registry identification number on the qualifying patient’s current registry identification card;
   e. The qualifying patient’s custodial parent’s or legal guardian’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   f. The qualifying patient’s custodial parent’s or legal guardian’s Arizona residence address and Arizona mailing address;
   g. The county where the qualifying patient’s custodial parent or legal guardian resides;
   h. The qualifying patient’s custodial parent’s or legal guardian’s e-mail address;
   i. The registry identification number on the qualifying patient’s custodial parent’s or legal guardian’s current registry identification card;
   j. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
   k. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the qualifying patient’s medical record maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;
   l. Whether the qualifying patient’s custodial parent or legal guardian is requesting approval for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient’s custodial parent or legal guardian believes that
the qualifying patient resides at least 25 miles from the nearest operating dispensary;
m. Whether the qualifying patient’s custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
n. A statement in a Department-provided format signed by the qualifying patient’s custodial parent or legal guardian who is serving as the qualifying patient’s designated caregiver:
   i. Allowing the qualifying patient’s medical use of marijuana;
   ii. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   iii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
o. An attestation that the information provided in the application is true and correct; and
p. The signature of the qualifying patient’s custodial parent or legal guardian and the date the qualifying patient’s custodial parent or legal guardian signed;
2. If the qualifying patient’s custodial parent’s or legal guardian’s name in subsection (B)(1)(e) is not the same name as on the qualifying patient’s custodial parent’s or legal guardian’s current registry identification card, one of the following with the custodial parent’s or legal guardian’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the qualifying patient’s custodial parent’s or legal guardian’s U.S. passport or a U.S. passport card;
3. A current photograph of the qualifying patient;
4. A written certification from the physician in subsection (B)(1)(j) and a separate written certification from the physician in subsection (B)(1)(k) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s renewal application that includes:
   a. The physician’s:
      i. Name,
      ii. License number including an identification of the physician license type,
iii. Office address on file with the physician’s licensing board,
iv. Telephone number on file with the physician’s licensing board, and
v. E-mail address;
b. The qualifying patient’s name and date of birth;
c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;
d. If the debilitating medical condition identified in subsection (B)(4)(c) is a condition in:
i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
ii. R9-17-201(14), the debilitating medical condition;
e. For the physician listed in subsection (B)(1)(j):
i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
ii. A statement, initialed by the physician, that the physician:
   (1) Has established a medical record for the qualifying patient, and
   (2) Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;
iv. The date the physician conducted the in-person physical examination of the qualifying patient;
v. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   (1) Medical records including medical records from other treating physicians from the previous 12 months,
   (2) Response to conventional medications and medical therapies, and
   (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
vi. A statement, initialed by the physician, that the physician has explained
the potential risks and benefits of the use of medical marijuana to the
qualifying patient’s custodial parent or legal guardian responsible for
health care decisions for the qualifying patient; and

vii. A statement, initialed by the physician, that the physician has provided
information to the qualifying patient’s custodial parent or legal guardian
responsible for health care decisions for the qualifying patient, if the
qualifying patient is female, that warns about:

(1) The potential dangers to a fetus caused by smoking or ingesting
marijuana while pregnant or to an infant while breastfeeding, and

(2) The risk of being reported to the Department of Child Safety
during pregnancy or at the birth of the child by persons who are
required to report;

f. For the physician listed in subsection (B)(1)(k), a statement, initialed by the
physician, that the physician conducted a comprehensive review of the qualifying
patient’s medical records from other treating physicians;

g. A statement, initialed by the physician, that, in the physician’s professional
opinion, the qualifying patient is likely to receive therapeutic or palliative benefit
from the qualifying patient’s medical use of marijuana to treat or alleviate the
qualifying patient’s debilitating medical condition;

h. A statement, initialed by the physician, that, if the physician has referred the
qualifying patient’s custodial parent or legal guardian to a dispensary, the
physician has disclosed to the qualifying patient’s custodial parent or legal
guardian any personal or professional relationship the physician has with the
dispensary;

i. An attestation that the information provided in the written certification is true and
correct; and

j. The physician’s signature and the date the physician signed; and

5. A current photograph of the qualifying patient’s custodial parent or legal guardian;

6. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:

a. The qualifying patient’s custodial parent’s or legal guardian’s fingerprints on a
fingerprint card that includes:

i. The qualifying patient’s custodial parent’s or legal guardian’s first name;
middle initial, if applicable; and last name;
ii. The qualifying patient’s custodial parent’s or legal guardian’s signature;

iii. If different from the qualifying patient’s custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient’s custodial parent’s or legal guardian’s fingerprints;

iv. The qualifying patient’s custodial parent’s or legal guardian’s address;

v. If applicable, the qualifying patient’s custodial parent’s or legal guardian’s surname before marriage and any names previously used by the qualifying patient’s custodial parent or legal guardian;

vi. The qualifying patient’s custodial parent’s or legal guardian’s date of birth;

vii. The qualifying patient’s custodial parent’s or legal guardian’s Social Security number;

viii. The qualifying patient’s custodial parent’s or legal guardian’s citizenship status;

ix. The qualifying patient’s custodial parent’s or legal guardian’s gender;

x. The qualifying patient’s custodial parent’s or legal guardian’s race;

xi. The qualifying patient’s custodial parent’s or legal guardian’s height;

xii. The qualifying patient’s custodial parent’s or legal guardian’s weight;

xiii. The qualifying patient’s custodial parent’s or legal guardian’s hair color;

xiv. The qualifying patient’s custodial parent’s or legal guardian’s eye color;

and

xv. The qualifying patient’s custodial parent’s or legal guardian’s place of birth; or

b. If the qualifying patient’s custodial parent’s or legal guardian’s fingerprints and information required in subsection (B)(6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the patient’s custodial parent or legal guardian serving as the qualifying patient’s designated caregiver as a result of the application; or

c. Documentation that the custodial parent or legal guardian has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and

7. The applicable fees in R9-17-102 for applying to renew a:
a. Qualifying patient’s registry identification card, and
b. Designated caregiver’s registry identification card.

C. Except as provided in subsection (A)(6), to renew a qualifying patient’s designated caregiver’s registry identification card, the qualifying patient shall submit to the Department, at least 30 calendar days before the expiration date of the designated caregiver’s registry identification card, the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The registry identification number on the qualifying patient’s current registry identification card;
   c. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   d. The designated caregiver’s date of birth;
   e. The designated caregiver’s Arizona residence address and Arizona mailing address;
   f. The county where the designated caregiver resides;
   g. The registry identification number on the designated caregiver’s current registry identification card;

2. If the designated caregiver’s name in subsection (C)(1)(a) is not the same name as on the designated caregiver’s current registry identification card, one of the following with the designated caregiver’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the designated caregiver’s U.S. passport or a U.S. passport card;

3. A current photograph of the designated caregiver;

4. A statement in a Department-provided format signed by the designated caregiver:
   a. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   b. Pledging not to divert marijuana to any individual or person who is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and

5. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   a. The designated caregiver’s fingerprints on a fingerprint card that includes:
      i. The designated caregiver’s first name; middle initial, if applicable; and
last name;

ii. The designated caregiver’s signature;

iii. If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;

iv. The designated caregiver’s address;

v. If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;

vi. The designated caregiver’s date of birth;

vii. The designated caregiver’s Social Security number;

viii. The designated caregiver’s citizenship status;

ix. The designated caregiver’s gender;

x. The designated caregiver’s race;

xi. The designated caregiver’s height;

xii. The designated caregiver’s weight;

xiii. The designated caregiver’s hair color;

xiv. The designated caregiver’s eye color; and

xv. The designated caregiver’s place of birth; or

b. If the designated caregiver’s fingerprints and information required in subsection (C)(1)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; or

c. Documentation that the designated caregiver has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and

6. The applicable fee in R9-17-102 for renewing a designated caregiver’s registry identification card.
ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS

R9-17-303. Dispensary Registration Certificate Allocation Process

A. Each calendar year, the Department may review current valid dispensary registration certificates to determine if the Department may issue additional dispensary registration certificates pursuant to A.R.S. § 36-2804(C).

1. If the Department determines that the Department may issue additional dispensary registration certificates, the Department shall post, on the Department’s website, the information that the Department is accepting dispensary registration certificate applications, including the deadline for accepting dispensary registration certificate applications.
   a. The Department shall post the information in subsection (A)(1) at least 30 calendar days before the date the Department begins accepting applications.
   b. The deadline for submission of dispensary registration certificate applications is 10 working days after the date the Department begins accepting applications.
   c. Sixty working days after the date the Department begins accepting applications, the Department shall determine if the Department received more dispensary registration certificate applications that are complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the Department is allowed to issue.
      i. If the Department received more dispensary registration certificate applications than the Department is allowed to issue, the Department shall allocate any available dispensary registration certificates according to the priorities established in subsection (B).
      ii. If the Department is allowed to issue a dispensary registration certificate for each dispensary registration certificate application the Department received, the Department shall allocate the dispensary registration certificates to those applicants.

2. If the Department determines that the Department is not allowed to issue additional dispensary registration certificates, the Department shall, on the Department’s website:
   a. Post the information that the Department is not accepting dispensary registration certificate applications, and
   b. Maintain the information until the next review.
B. If the Department receives, by 60 working days after the date the Department begins accepting applications determined, according to subsection (A)(1)(c), that more dispensary registration certificate applications were received that are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the number of dispensary registration certificates the Department is allowed to issue, the Department shall allocate the dispensary registration certificates according to the following criteria:

1. For dispensary registration certificate applications are received for a county that does not contain a dispensary:
   a. If only one dispensary registration certificate application is received for a proposed dispensary located in the county, the Department shall allocate the dispensary registration certificate to that applicant; or
   b. If more than one dispensary registration certificate application is received for a proposed dispensary located in the county, the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to subsection (B)(2);

2. For dispensary registration certificate applications received according to subsection (B)(1)(b), the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to the following:
   a. If only one dispensary registration certificate application is received for a proposed dispensary located in a geographic area in the county, at a location that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall allocate the dispensary registration certificate to that applicant;
   b. If more than one dispensary registration certificate application is received for a proposed dispensary located in a geographic area in the county, at a location that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall:
      i. prioritize and allocate a dispensary registration certificate to an applicant based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary location, as determined from the number of registry identification cards issued to qualifying patients; and
ii. If two or more dispensary registration certificate applications specify the same location from which another dispensary has moved, comply with subsection (C); and

c. If no dispensary registration certificate applications are received for a proposed dispensary located in a geographic area in the county, at a location that meets the criteria in subsection (2)(a) is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall allocate a dispensary registration certificate in the county as follows:

i. If only one dispensary registration certificate application is received for a proposed dispensary located in a geographic area in the county at a location that is at least 25 miles from another dispensary, the Department shall allocate the dispensary registration certificate to that applicant;

ii. If more than one dispensary registration certificate application is received for a proposed dispensary located in a geographic area in the county at a location that is at least 25 miles from another dispensary, the Department shall allocate a dispensary registration certificate to an applicant at a location that is at least 25 miles from another dispensary based on random drawing; and

iii. If no dispensary registration certificate is allocated according to subsection (B)(2)(c)(i) or (ii), the Department shall allocate a dispensary registration certificate to an applicant for a proposed dispensary located in the county based on random drawing;

3. If additional dispensary registration certificates are available after dispensary registration certificates are allocated, for a county, that does not contain a dispensary for each county in which no dispensary is located, according to subsection (B)(1) or (2), the Department shall allocate the additional dispensary registration certificates for a location in any geographic area as follows to applicants who applied for a proposed dispensary location outside of the open counties:

a. If only one the number of dispensary registration certificate application is applications received for a proposed dispensary located in a geographic area at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1) or (2), and from which another dispensary has moved since the previous allocation of dispensary registration certificates is less than or equal to the number of
available dispensary registration certificates, the Department shall allocate the dispensary registration certificate certificates to that applicant those applicants; or

b. If more than one the number of dispensary registration certificate application is applications received for a proposed dispensary located in a geographic area at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1) or (2), and from which another dispensary has moved since the previous allocation of dispensary registration certificates is greater than the number of available dispensary registration certificates, the Department shall:

i. prioritize Prioritize and allocate dispensary registration certificates to applicants based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary location, as determined from the number of registry identification cards issued to qualifying patients; and

ii. If two or more dispensary registration certificate applications specify the same location from which another dispensary has moved, comply with subsection (C);

4. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1), (2), and (3), the Department shall allocate the dispensary registration certificates for a location in any geographic area as follows:

a. If only one the number of dispensary registration certificate application is applications received for a proposed dispensary located in a geographic area in which there are no other dispensaries operating within 25 miles of the geographic area at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection (B)(1), (2), or (3), is less than or equal to the number of available dispensary registration certificates, the Department shall allocate a dispensary registration certificate to that applicant those applicants; or

b. If more than one the number of dispensary registration certificate application is applications received for a proposed dispensary located in a geographic area in which there are no other dispensaries operating within 25 miles of the geographic area at a location that is at least 25 miles from another dispensary, including a dispensary allocated a dispensary registration certificate according to subsection
If the number of applications received in subsections (B)(1), (2), or (3), is greater than the number of available dispensary registration certificates, the Department shall allocate a dispensary registration certificate to an applicant:

i. based on random drawing; and

ii. If two or more dispensary registration certificate applications specify the same location, comply with subsection (C); and

5. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1) through (4), for all dispensary registration certificate applications not allocated a dispensary registration certificate, the Department shall allocate a dispensary registration certificate to an applicant:

a. based on random drawing; and

b. If two or more dispensary registration certificate applications specify the same location, comply with subsection (C).

C. If there is a tie or a margin of 0.1% or less in the scores generated by applying the criteria in subsection (B), the Department shall randomly select one dispensary registration certificate application and allocate for allocation of a dispensary registration certificate to that applicant if:

1. There is a tie or a margin of 0.1% or less in the scores generated by applying the criteria in subsection (B), or

2. Two or more dispensary registration certificate applications specify the same location.

D. For purposes of subsection (B):

1. “Five miles” includes the area contained within a circle that extends for five miles in all directions from a specific location, not the distance travelled from the specific location by road; and

2. “25 miles” includes the area contained within a circle that extends for 25 miles in all directions from the center of a geographic area, a proposed dispensary location, not the distance travelled from the center of the geographic area one location to another location by road.

E. If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process, the Department shall:

4. Provide a written notice to the applicant that states that, although the applicant’s dispensary registration certificate application was complete and complied with A.R.S.
Title 36, Chapter 28.1 and this Chapter, the Department did not allocate the applicant a dispensary registration certificate under the processes in this Section; and

2. Return $1,000 of the application fee to the applicant.

F. If the Department receives a dispensary registration certificate application at a time other than the time stated in subsection (B), the Department shall return the dispensary registration certificate application, including the application fee, to the applicant.

R9-17-304. Applying for a Dispensary Registration Certificate

A. An individual shall not be an applicant, a principal officer, or board member on:

1. More than one dispensary registration certificate application for a location in a single geographic area, or

2. More than five dispensary registration certificate applications for locations in different geographic areas.

B. If the Department determines that an individual is an applicant, a principal officer, or board member on more than one dispensary registration certificate application for a geographic area or more than five dispensary registration certificate applications, the Department shall review the applications and provide the applicant on each of the dispensary registration certificate applications with a written comprehensive request for more information that includes the specific requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter that the dispensary registration certificate application does not comply with.

1. If an applicant withdraws an application to comply with this Chapter and submits information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall process the applicant’s remaining dispensary registration certificate applications according to this Chapter.

2. If an applicant does not withdraw an application or submit information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue a denial to the applicant according to R9-17-322.

3. An application fee submitted with a dispensary registration certificate application in subsection (B) that is withdrawn is not refunded.

C. To apply for a dispensary registration certificate, an applicant shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The legal name of the proposed dispensary;
   b. The physical address and geographic area of the proposed dispensary;
   c. The name of the geographic area;
d. The county in which the geographic area in subsection (C)(1)(c) is located;

e. If applicable, the name of the dispensary that previously held a dispensary registration certificate at the physical address of the proposed dispensary and the approximate date the dispensary left the location;

f. The following information for the applicant:
   i. Name of the individual or entity applying,
   ii. Type of business organization,
   iii. Mailing Arizona mailing address,
   iv. Telephone number, and
   v. E-mail address;

g. The name of the individual principal officer or board member designated to submit dispensary agent registry identification card applications on behalf of the proposed dispensary;

h. The name and professional license number of the proposed dispensary’s medical director;

i. The name, residence address, and date of birth of each:
   i. Principal officer, and
   ii. Board member;

j. For each principal officer or board member, whether the principal officer or board member:
   i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked;
   ii. Is a physician currently providing written certifications for qualifying patients;
   iii. Is a law enforcement officer; or
   iv. Is employed by or a contractor of the Department;

k. Whether the applicant agrees to allow the Department to submit supplemental requests for information;

l. A statement that, if the applicant is issued a dispensary registration certificate, the proposed dispensary will not operate until the proposed dispensary is inspected and obtains an approval to operate from the Department;

m. A statement that the applicant understands that, if the applicant is issued a dispensary registration certificate, the dispensary may relocate only as specified in A.R.S. § 36-2803.01(D);
j-m. An attestation that the information provided to the Department to apply for a dispensary registration certificate is true and correct; and

k-n. The signatures of each principal officer and each board member of the proposed dispensary according to R9-17-301 and the date signed;

2. If the applicant is one of the business organizations in R9-17-301(A)(2) through (7), a copy of the business organization’s articles of incorporation, articles of organization, or partnership or joint venture documents that include: documentation that the applicant is in good standing with the Arizona Corporation Commission;
   a. The name of the business organization,
   b. The type of business organization, and
   c. The names and titles of the individuals in R9-17-301(A) and (B);

3. For each principal officer and each board member:
   a. An attestation signed and dated by the principal officer or board member that the principal officer or board member:
      i. has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
      ii. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
   b. For the Department’s criminal records check authorized in A.R.S. §§ 36-2804 and 36-2804.05:
      i. The principal officer’s or board member’s fingerprints on a fingerprint card that includes:
         (1) The principal officer’s or board member’s first name; middle initial, if applicable; and last name;
         (2) The principal officer’s or board member’s signature;
         (3) If different from the principal officer or board member, the signature of the individual physically rolling the principal officer’s or board member’s fingerprints;
         (4) The principal officer’s or board member’s residence address;
         (5) If applicable, the principal officer’s or board member’s surname before marriage and any names previously used by the principal officer or board member;
         (6) The principal officer’s or board member’s date of birth;
(7) The principal officer's or board member's Social Security number;
(8) The principal officer's or board member's citizenship status;
(9) The principal officer's or board member's gender;
(10) The principal officer's or board member's race;
(11) The principal officer's or board member's height;
(12) The principal officer's or board member's weight;
(13) The principal officer's or board member's hair color;
(14) The principal officer's or board member's eye color; and
(15) The principal officer's or board member's place of birth; or
ii. If the fingerprints and information required in subsection (C)(3)(b)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the principal officer or board member as a result of the application;

b. Documentation that the principal officer or board member has a valid marijuana facility agent license;

4. Policies and procedures that comply with the requirements in this Chapter for:
a. Inventory control,
b. Laboratory testing of medical marijuana and medical marijuana products,
c. Qualifying patient recordkeeping, and
d. Security, and
e. Patient education and support;

5. As required in A.R.S. § 36-2804(B)(1)(d), a sworn statement, signed and dated by each principal officer and each board member of the proposed dispensary according to R9-17-301, certifying that the proposed dispensary is in compliance with any local zoning restrictions;

6. Documentation from the local jurisdiction where the proposed dispensary's physical address is located that:
a. There are no local zoning restrictions for the proposed dispensary's location, or
b. The proposed dispensary's location is in compliance with any local zoning restrictions;
6. A statement, in a Department-provided format, signed and dated within 60 calendar days before the date of the application by a representative of the local jurisdiction:
   a. Certifying that the proposed dispensary is in compliance with any local zoning restrictions; and
   b. Including:
      i. Information identifying the local jurisdiction and the local jurisdiction’s representative,
      ii. The legal name of the proposed dispensary, and
      iii. The physical address of the proposed dispensary as specified according to subsection (C)(1)(b);

7. Documentation, in a Department-provided format, of:
   a. Ownership by the applicant of the physical address of the proposed dispensary, signed and dated within 60 calendar days before the date of the application; or
   b. Permission from the owner of the physical address of the proposed dispensary for the applicant for a dispensary registration certificate to operate a dispensary at the physical address, signed, notarized, and dated within 60 calendar days before the date of the application;

8. The proposed dispensary’s by-laws including:
   a. The names and titles of individuals designated as principal officers and board members of the proposed dispensary;
   b. Whether the proposed dispensary plans to:
      i. Cultivate marijuana;
      ii. Acquire marijuana from qualifying patients, designated caregivers, or other dispensaries;
      iii. Sell or provide marijuana to other dispensaries;
      iv. Transport marijuana;
      v. Prepare, sell, or dispense marijuana-infused edible food products;
      vi. Prepare, sell, or dispense marijuana-infused non-edible products;
      vii. Sell or provide marijuana paraphernalia or other supplies related to the administration of marijuana to qualifying patients and designated caregivers;
      viii. Deliver medical marijuana to qualifying patients; or
      ix. Provide patient support and related services to qualifying patients;
   c. Provisions for the disposition of revenues and receipts to ensure that the proposed
dispensary operates on a not-for-profit basis; and


d. Provisions for amending the proposed dispensary’s by-laws;

9. A business plan demonstrating the on-going viability of the proposed dispensary on a not-for-profit basis that includes:

a. A description and total dollar amount of expenditures already incurred to establish the proposed dispensary or to secure a dispensary registration certificate by the applicant for the dispensary registration certificate;

b. A description and total dollar amount of monies or tangible assets received for operating the proposed dispensary from entities other than the applicant for the dispensary registration certificate or a principal officer or board member associated with the applicant, including the entity’s name and the interest in the dispensary or the benefit the entity obtained;

c. Projected expenditures expected before the proposed dispensary is operational;

d. Projected expenditures after the dispensary is operational; and

e. Projected revenue; and

10.8. The applicable fee in R9-17-102 for applying for a dispensary registration certificate.

D. Before an entity with a dispensary registration certificate begins operating a dispensary, the entity shall apply for and obtain an approval to operate a dispensary from the Department.

R9-17-305. Applying for Approval to Operate a Dispensary

A. To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit to the Department, and, if the dispensary registration certificate was issued on or after April 1, 2020, within 18 months after the dispensary registration certificate was issued, the following:

1. An application in a Department-provided format that includes:

a. The name and registry identification number of the dispensary;

b. The physical address of the dispensary;

c. The name, address, and date of birth of each dispensary agent;

d. Except as provided in R9-17-324, the name and professional license number of the dispensary’s medical director;

e. If applicable, the physical address of the dispensary’s cultivation site;

f. The dispensary’s Transaction Privilege Tax Number issued by the Arizona Department of Revenue;

g. The dispensary’s proposed hours of operation during which the dispensary plans to be available to dispense medical marijuana to qualifying patients and
designated caregivers;

h. Whether the dispensary plans to:
   i. Cultivate marijuana;
   ii. Manufacture marijuana products;
   iii. Prepare marijuana-infused edible products; or
   iv. Sell or dispense marijuana-infused edible products that are either:
      (1) A time/temperature control for safety food, or
      (2) Not prepared in individually packaged containers;

h.i. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;

i.j. Whether the dispensary and, if applicable, the dispensary’s cultivation site are ready for an inspection by the Department;

j.k. If the dispensary and, if applicable, the dispensary’s cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary’s cultivation site will be ready for an inspection by the Department;

k.l. An attestation that the information provided to the Department to apply for approval to operate a dispensary is true and correct; and

l.m. The signatures of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;

2. A copy of the dispensary’s license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the dispensary plans to:
   a. Prepare marijuana-infused edible food products, as specified in subsection (A)(1)(h)(iii); or
   b. Sell or dispense marijuana-infused edible food products, as specified in subsection (A)(1)(h)(iv);

2-3. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary’s cultivation site, such as a certificate of occupancy, a special use permit, or a conditional use permit;

3. A sworn statement, signed and dated by each principal officer and each board member of the dispensary according to R9-17-301, certifying that the dispensary is in compliance with local zoning restrictions;

4. The distance to the closest private school or public school from:
a. The dispensary; and  
b. If applicable, the dispensary’s cultivation site;  

5. A site plan drawn to scale of the dispensary location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;  

6. A floor plan drawn to scale of the building where the dispensary is located showing the:  
   a. Layout and dimensions of each room,  
   b. Name and function of each room,  
   c. Location of each hand washing sink,  
   d. Location of each toilet room,  
   e. Means of egress,  
   f. Location of each video camera,  
   g. Location of each panic button, and  
   h. Location of natural and artificial lighting sources;  

7. If applicable, a site plan drawn to scale of the dispensary’s cultivation site showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and  

8. If applicable, a floor plan drawn to scale of each building at the dispensary’s cultivation site showing the:  
   a. Layout and dimensions of each room,  
   b. Name and function of each room,  
   c. Location of each hand washing sink,  
   d. Location of each toilet room,  
   e. Means of egress,  
   f. Location of each video camera,  
   g. Location of each panic button, and  
   h. Location of natural and artificial lighting sources.  

B. A dispensary’s cultivation site may be located anywhere in the state where a cultivation site is allowed by the local jurisdiction.  

R9-17-306. Changes to a Dispensary Registration Certificate  
A. Except as provided in R9-17-324, a dispensary may not transfer or assign the dispensary registration certificate.  
B. A dispensary may change the location of the:
1. Dispensary:
   a. If the dispensary was allocated a dispensary registration certificate on or after April 1, 2020, according to A.R.S. § 36-2803.01(D); and
   b. If the dispensary was allocated a dispensary registration certificate before April 1, 2020:
      i. Within the first three years after the Department issued the dispensary’s registration certificate, to another location in the geographic area where the dispensary is located; or
      ii. After the first three years after the Department issued a dispensary registration certificate to the dispensary, to another location in the state; or
   2. Dispensary’s cultivation site to another location in the state.

C. A dispensary or the dispensary’s cultivation site shall not cultivate, manufacture, distribute, dispense, or sell medical marijuana at a new location or make a change in the activities conducted at a current location until the dispensary:
   1. submits an application for a change in a dispensary location or a change or addition of a cultivation site in R9-17-307; and
   2. the Department issues an amended dispensary registration certificate or an approval for:
      a. The dispensary’s cultivation site’s new location to the dispensary, including the activities to be conducted at the new location;
      b. The dispensary’s cultivation site’s new location, including the activities to be conducted at the new location; or
      c. The requested change in the activities conducted at a current location.

R9-17-307. Applying to Change a Dispensary’s Location or Change or Add a Dispensary’s Cultivation Site Dispensary Registration Certificate

A. A dispensary shall submit a separate application to the Department for each request for one of the possible changes in R9-17-306(C).

B. To change the location of a dispensary or the dispensary’s cultivation site or to add a cultivation site, the To request any of the changes specified in R9-17-306(C), a dispensary shall submit an application to the Department that includes:
   1. The following information in a Department-provided format:
      a. The legal name of the dispensary;
      b. The registry identification number for the dispensary;
c. Whether the request is for:
   i. A change of location for the dispensary,
   ii. A change of location for the dispensary’s cultivation site, or
   iii. An addition of a cultivation site, or
   iv. A change in the activities conducted at a current location;

d. The current physical address of the dispensary or the dispensary’s cultivation site;

e. The physical address of the proposed location for the dispensary or the dispensary’s cultivation site, if applicable;

f. The distance to the closest public school or private school from:
   i. The proposed location for the dispensary, or
   ii. The proposed location for the dispensary’s cultivation site;

g. For a request to change activities conducted at a current location or include any of the following activities at a new location, whether the dispensary plans to:
   i. Cultivate marijuana;
   ii. Manufacture marijuana products;
   iii. Prepare marijuana-infused edible products; or
   iv. Sell or dispense marijuana-infused edible products that are either:
      (1) A time/temperature control for safety food, or
      (2) Not prepared in individually packaged containers;

h. The name of the entity applying;

i. If applicable, the anticipated date of the change of location or activities;

j. Whether the proposed dispensary, or the dispensary’s proposed cultivation site, or the location of the change in activities is ready for an inspection by the Department;

k. If the proposed dispensary, or the dispensary’s proposed cultivation site, or the location of the change in activities is not ready for an inspection by the Department, the date the dispensary, or the dispensary’s proposed cultivation site, or the location of the change in activities will be ready for an inspection by the Department;

l. An attestation that the information provided to the Department to apply for a change in location is true and correct; and

m. The signature of each principal officer and each board member of the dispensary
according to R9-17-301 and the date signed;

2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the proposed building as a dispensary or location as the dispensary’s cultivation site for the activities to be conducted at the location, such as a certificate of occupancy, a special use permit, or a conditional use permit;

3. A sworn statement, signed by each principal officer and board member of the dispensary according to R9-17-301, certifying that the location of the proposed dispensary building or of the dispensary’s proposed cultivation site is in compliance with local zoning restrictions;

3. A copy of the dispensary’s license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, if the dispensary plans to:
   a. Prepare marijuana-infused edible food products, as specified in subsection (B)(1)(g)(iii); or
   b. Sell or dispense marijuana-infused edible food products, as specified in subsection (B)(1)(g)(iv);

4. A copy of documentation, in a Department-provided format, of:
   a. Ownership of the physical address of the proposed dispensary, proposed cultivation site, or location for the change in activities, signed and dated within 60 calendar days before the date of the request; or
   b. Permission from the owner of the physical address of the proposed dispensary, proposed cultivation site, or location for the change in activities, for the dispensary to operate a dispensary or conduct the specified activities at the physical address, signed, notarized, and dated within 60 calendar days before the date of the request;

4.5. If the change in location is for the dispensary:
   a. A site plan drawn to scale of the proposed dispensary location showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
   b. A floor plan drawn to scale of the building where the proposed dispensary is located showing the:
      i. Layout and dimensions of each room,
      ii. Name and function of each room,
      iii. Location of each hand washing sink,
iv. Location of each toilet room,
v. Means of egress,
vi. Location of each video camera,
vii. Location of each panic button, and
viii. Location of natural and artificial lighting sources;

5.6. If the change in location is for the dispensary’s cultivation site or if adding a cultivation site:

a. A site plan drawn to scale of the dispensary’s proposed cultivation site showing streets, property lines of the contiguous premises, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and

b. If applicable, a floor plan drawn to scale of each building used by the dispensary’s proposed cultivation site showing the:

i. Layout and dimensions of each room,
ii. Name and function of each room,
iii. Location of each hand washing sink,
iv. Location of each toilet room,
v. Means of egress,
vi. Location of each video camera,
vii. Location of each panic button, and
viii. Location of natural and artificial lighting sources; and

6.7. The applicable fee in R9-17-102 for applying for a change in location or the addition of a cultivation site.

B.C. If the information and documents submitted by the dispensary comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue an amended dispensary registration certificate that includes the new address of the new location or the new activities and retains the expiration date of the previously issued dispensary registration certificate.

C.D. An application for a change in location of a dispensary or a dispensary’s cultivation site or the addition of a cultivation site may not be combined with an application for renewing a dispensary registration certificate. The Department shall process each application separately according to the applicable time-frame established in R9-17-107.

D.E. A dispensary shall submit written notification to the Department when the dispensary no longer uses a previously approved cultivation site.
R9-17-308. Renewing a Dispensary Registration Certificate

To renew a dispensary registration certificate, a dispensary that has an approval to operate a dispensary issued by the Department, shall submit to the Department, at least 30 calendar days before the expiration date of the dispensary’s current dispensary registration certificate, the following:

1. An application in a Department-provided format that includes:
   a. The legal name of the dispensary;
   b. The registry identification number for the dispensary;
   c. If the dispensary is a dual licensee, the marijuana establishment license number;
   d. The physical address of the dispensary;
   e. The name of the entity applying;
   f. Except as provided in R9-17-324(D), the name and license number of the dispensary’s medical director;
   g. The dispensary’s hours of operation during which the dispensary is available to dispense medical marijuana to qualifying patients and designated caregivers;
   h. The name, address, date of birth, and registry identification number of each:
      i. Principal officer,
      ii. Board member, and
      iii. Dispensary agent;
   i. For each principal officer or board member, whether the principal officer or board member:
      i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked,
      ii. Has served as a principal officer or board member for a marijuana establishment that had the marijuana establishment license revoked, or
      iii. Is a physician currently providing written certifications for qualifying patients;
      iv. Is a law enforcement officer, or
      v. Is employed by or a contractor of the Department;
   j. The dispensary’s Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
   k. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
   l. An attestation that the information provided to the Department to renew the dispensary registration certificate is true and correct; and
m. The signature of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;

2. If the application is for renewing a dispensary registration certificate that was initially issued within the previous 12 months, a copy of the dispensary's approval to operate a dispensary issued by the Department;

3. Except as specified in R9-17-324(E) Either:
   a. An attestation, in a Department-provided format, that the dispensary is operating on a not-for-profit basis; or
   b. Both of the following:
      a.i. A copy of an annual financial statement for the previous two years, or for the portion of the previous two years the dispensary was operational, prepared according to generally accepted accounting principles; and
      b.ii. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (3)(a) (2)(b)(i); and

4. The applicable fee in R9-17-102 for applying to renew a dispensary registration certificate.

R9-17-310. Administration

A. A dispensary shall:

1. Ensure that the dispensary is operating and available to dispense medical marijuana and marijuana products to qualifying patients and designated caregivers:
   a. At least 30 hours weekly between the hours of 7:00 a.m. and 10:00 p.m.; and
   b. For a dispensary with a dispensary registration certificate issued on or after April 1, 2020:
      i. At the location specified according to R9-17-304(C)(1)(b), and
      ii. within 18 months after receiving the dispensary registration certificate;

2. Develop, document, and implement policies and procedures regarding:
   a. Job descriptions and employment contracts, including:
      i. Personnel duties, authority, responsibilities, and qualifications;
      ii. Personnel supervision;
      iii. Training in and adherence to confidentiality requirements;
      iv. Periodic performance evaluations; and
      v. Disciplinary actions;
   b. Business records, such as manual or computerized records of assets and
liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;

c. Inventory control, including:
   i. Tracking;
   ii. Packaging;
   iii. Accepting marijuana from qualifying patients and designated caregivers;
   iv. Acquiring marijuana or marijuana products from other dispensaries;
   v. Providing marijuana or marijuana products to another dispensary; and
   vi. Either:
      (1) Providing samples of marijuana or marijuana products to a laboratory for testing, or
      (2) Allowing a laboratory agent access to medical marijuana or marijuana product to collect samples;

d. Laboratory testing, including:
   i. The analytes, including possible contaminants, to be tested for;
   ii. The process for separating a batch of marijuana or of a marijuana product until laboratory testing has been completed and testing results received by the dispensary;
   iii. The process for collecting samples of medical marijuana or a marijuana product for laboratory testing, including:
      (1) The amount to be collected from each batch,
      (2) The method for ensuring that a sample collected is representative of the batch,
      (3) The packaging of the sample,
      (4) The method for documenting chain of custody for the sample, and
      (5) Methods to deter tampering with the sample and to determine whether tampering has occurred;
   vi. The process for submitting a sample of medical marijuana or a marijuana product to a laboratory agent or laboratory for testing;
   v. The process for requesting retesting of the remaining portion of a sample of medical marijuana or a marijuana product; and
   vi. Actions to be taken on the basis of laboratory testing results;

e. Remediation, including:
i. Criteria for when a batch of medical marijuana or marijuana product can be remediated;

ii. The process by which each type of medical marijuana or marijuana product is remediated, including the methods for remediation and subsequent retesting; and

iii. Documentation of the remediation process;

f. Disposal of medical marijuana or a marijuana product, including:

i. Destroying a batch of marijuana or a marijuana product that does not meet the requirements in Table 3.1 and documenting the destruction;

ii. Submitting marijuana that is not usable marijuana to a local law enforcement agency and documenting the submission; or

iii. Otherwise disposing of marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting the method of disposal, the laboratory agent overseeing the disposal, and the date of disposal;

g. Qualifying patient records, including purchases, denials of sale, any delivery options, confidentiality, and retention; and

h. Patient education and support, including the development and distribution of materials on:

i. Availability of different strains of marijuana and the purported effects of the different strains;

ii. Information about the purported effectiveness of various methods, forms, and routes of medical marijuana administration;

iii. Information about laboratory testing, the analytes for which the dispensary receives testing results, the right to receive a copy of the final report of testing specified in R9-17-404.06 upon request, and how to read and understand the final report of testing;

iv. Methods of tracking the effects on a qualifying patient of different strains and forms of marijuana; and

v. Prohibition on the smoking of medical marijuana in public places;

3. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request;

4. Review dispensary policies and procedures at least once every 12 months from the issue date of the dispensary registration certificate and update as needed;
5. Except as provided in R9-17-324(D), employ or contract with a medical director;

6. Except as provided in R9-17-324(C), ensure that each dispensary agent or marijuana facility agent associated with the dispensary has the applicable registry identification card or marijuana facility agent license in the dispensary agent’s or marijuana facility agent’s immediate possession when the dispensary agent or marijuana facility agent is:
   a. Working or providing volunteer services at the dispensary or the dispensary’s cultivation site, or
   b. Transporting marijuana for the dispensary;

7. Except as provided in R9-17-324(C), ensure that a dispensary agent or marijuana facility agent associated with the dispensary accompanies any individual other than another dispensary agent or marijuana facility agent associated with the dispensary when the individual is present in the enclosed, locked facility where marijuana is cultivated by the dispensary;

8. Except as provided in R9-17-324(C), not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate or marijuana facility agent license associated with the dispensary to:
   a. Serve as a principal officer or board member for the dispensary,
   b. Serve as the medical director for the dispensary,
   c. Be employed by the dispensary, or
   d. Provide volunteer services at or on behalf of the dispensary;

9. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a dispensary agent or marijuana facility agent associated with the dispensary no longer:
   a. Serves as a principal officer or board member for the dispensary,
   b. Serves as the medical director for the dispensary,
   c. Is employed by the dispensary, or
   d. Provides volunteer services at or on behalf of the dispensary;

10. Document and report any loss or theft of marijuana from the dispensary to the appropriate law enforcement agency;

11. Maintain copies of any documentation required in this Chapter for at least 12 months after the date on the documentation and provide copies of the documentation to the Department for review upon request;

12. Post the following information in a place that can be viewed by individuals entering the
dispensary:
   a. If applicable, the dispensary’s approval to operate;
   b. The dispensary’s registration certificate;
   c. Except as provided in R9-17-324(D), the name of the dispensary’s medical
director and the medical director’s professional license number on a sign at least
   20 centimeters by 30 centimeters;
   d. The hours of operation during which the dispensary will dispense medical
   marijuana to a qualifying patient or a designated caregiver;
   e. A sign in a Department-provided format that contains the following language:
      i. “WARNING: There may be potential dangers to fetuses caused by
         smoking or ingesting marijuana while pregnant or to infants while
         breastfeeding,” and
      ii. “WARNING: Use of marijuana during pregnancy may result in a risk of
         being reported to the Department of Child Safety during pregnancy or at
         the birth of the child by persons who are required to report;” and
      iii. A sign stating that a qualifying patient has the right to receive the results
         of laboratory testing of medical marijuana or a marijuana product; and
   f. A sign stating that a qualifying patient has the right to receive the results of
   laboratory testing of medical marijuana or a marijuana product; and

13. Except as provided in R9-17-324(D):
   a. Not lend any part of the dispensary’s income or property without receiving
      adequate security and a reasonable rate of interest,
   b. Not purchase property for more than adequate consideration in money or cash
      equivalent,
   c. Not pay compensation for salaries or other compensation for personal services
      that is in excess of a reasonable allowance,
   d. Not sell any part of the dispensary’s property or equipment for less than adequate
      consideration in money or cash equivalent, and
   e. Not engage in any other transaction that results in a substantial diversion of the
      dispensary’s income or property.

B. If a dispensary cultivates marijuana, the dispensary shall cultivate the marijuana in an enclosed,
locked facility.

R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card

Except as provided in R9-17-107(F) or R9-17-324(C), to obtain a dispensary agent registry identification
card for an individual serving as a principal officer or board member for the dispensary, employed by the dispensary, or providing volunteer services at or on behalf of the dispensary, the dispensary shall submit to the Department the following for each individual:

1. An application in a Department-provided format that includes:
   a. The individual’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The individual’s residence address and Arizona mailing address;
   c. The county where the individual resides;
   d. The individual’s date of birth;
   e. The identifying number on the applicable card or document in subsection (5)(a) (4)(a) through (e);
   f. The name and registry identification number of the dispensary; and
   g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary’s behalf and the date signed;

2. An attestation signed and dated by the individual that the individual:
   a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
   b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

3. One of the following:
   a. A statement that the individual does not currently hold a valid registry identification card, or
   b. The assigned registry identification number for the individual for each valid registry identification card currently held by the individual;

4. A statement in a Department-provided format signed by the individual pledging not to divert marijuana to any other individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A copy of the individual’s:
   a. Arizona driver’s license issued on or after October 1, 1996;
   b. Arizona identification card issued on or after October 1, 1996;
   c. Arizona registry identification card;
   d. Photograph page in the individual’s U.S. passport or a U.S. passport card; or
e. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the individual:
   i. Birth certificate verifying U.S. citizenship,
   ii. U.S. Certificate of Naturalization, or
   iii. U.S. Certificate of Citizenship;

6-5. A current photograph of the individual;

7-6. For the Department’s criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.05:

a. The individual’s fingerprints on a fingerprint card that includes:
   i. The individual’s first name; middle initial, if applicable; and last name;
   ii. The individual’s signature;
   iii. If different from the individual, the signature of another individual physically rolling the individual’s fingerprints;
   iv. The individual’s address;
   v. If applicable, the individual’s surname before marriage and any names previously used by the individual;
   vi. The individual’s date of birth;
   vii. The individual’s Social Security number;
   viii. The individual’s citizenship status;
   ix. The individual’s gender;
   x. The individual’s race;
   xi. The individual’s height;
   xii. The individual’s weight;
   xiii. The individual’s hair color;
   xiv. The individual’s eye color; and
   xv. The individual’s place of birth; or

b. If the individual’s fingerprints and information required in subsection 7-6(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card for another dispensary, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the individual as a result of the application; or

c. Documentation that the individual has a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07; and
8.7. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.

R9-17-312. Submitting an Application to Renew a Dispensary Agent’s Registry Identification Card

To renew a dispensary agent’s registry identification card, a dispensary shall submit to the Department, at least 30 calendar days before the expiration of the dispensary agent’s registry identification card, the following:

1. An application in a Department-provided format that includes:
   a. The dispensary agent’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The dispensary agent’s residence address and Arizona mailing address;
   c. The county where the dispensary agent resides;
   d. The dispensary agent’s date of birth;
   e. The registry identification number on the dispensary agent’s current registry identification card;
   f. The name and registry identification number of the dispensary;
   g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary’s behalf and the date signed;

2. An attestation signed and dated by the dispensary agent that the dispensary agent:
   a. Has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801, or
   b. Is deemed to not have been convicted of an excluded felony offense through holding a valid level I fingerprint clearance card issued according to A.R.S. § 41-1758.07;

3. If the dispensary agent’s name in subsection (1)(a) is not the same name as on the dispensary agent’s current registry identification card, one of the following with the dispensary agent’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the dispensary agent’s U.S. passport or a U.S. passport card;

4. A statement in a Department-provided format signed by the dispensary agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess
marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A current photograph of the dispensary agent;

6. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   a. The dispensary agent’s fingerprints on a fingerprint card that includes:
      i. The dispensary agent’s first name; middle initial, if applicable; and last
         name;
      ii. The dispensary agent’s signature;
      iii. If different from the dispensary agent, the signature of the individual
           physically rolling the dispensary agent’s fingerprints;
      iv. The dispensary agent’s address;
      v. If applicable, the dispensary agent’s surname before marriage and any
         names previously used by the dispensary agent;
      vi. The dispensary agent’s date of birth;
      vii. The dispensary agent’s Social Security number;
      viii. The dispensary agent’s citizenship status;
      ix. The dispensary agent’s gender;
      x. The dispensary agent’s race;
      xi. The dispensary agent’s height;
      xii. The dispensary agent’s weight;
      xiii. The dispensary agent’s hair color;
      xiv. The dispensary agent’s eye color; and
      xv. The dispensary agent’s place of birth; or
   b. If the dispensary agent’s fingerprints and information required in subsection
      (6)(a) were submitted to the Department as part of an application for a designated
      caregiver registry identification card, dispensary agent registry identification card
      for another dispensary, or laboratory agent registry identification card within the
      previous six months, the registry identification number on the registry
      identification card issued to the dispensary agent as a result of the application; or
   c. Documentation that the dispensary agent has a valid level I fingerprint clearance
      card issued according to A.R.S. § 41-1758.07; and

7. The applicable fee in R9-17-102 for applying to renew a dispensary agent’s registry
   identification card.

R9-17-316. Inventory Control System

A. A dispensary shall designate in writing a dispensary agent or marijuana facility agent associated
with the dispensary who has oversight of the dispensary’s medical marijuana inventory control system.

B. A dispensary shall only acquire marijuana from:
1. The dispensary’s cultivation site,
2. Another dispensary or another dispensary’s cultivation site,
3. A marijuana establishment licensed under 9 A.A.C. 18,
3-4. A qualifying patient authorized by the Department to cultivate marijuana, or
4.5. A designated caregiver authorized by the Department to cultivate marijuana.

C. A dispensary shall establish and implement an inventory control system for the dispensary’s medical marijuana and marijuana products that documents:
1. The following amounts:
   a. Each day’s beginning inventory of medical marijuana and marijuana products,
   b. Acquisitions according to subsection (B),
   c. Medical marijuana harvested by the dispensary,
   d. Medical marijuana and marijuana products provided to another dispensary,
   e. Medical marijuana and marijuana products dispensed to a qualifying patient or designated caregiver,
   f. Medical marijuana and marijuana products submitted to a laboratory for testing according to R9-17-317.01,
   g. Medical marijuana or marijuana products that were disposed of, and
   h. The day’s ending medical marijuana and marijuana products inventory;
2. For acquiring medical marijuana from a qualifying patient or designated caregiver:
   a. A description of the medical marijuana acquired including the amount and strain,
   b. The name and registry identification number of the qualifying patient or designated caregiver who provided the medical marijuana,
   c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent receiving the medical marijuana on behalf of the dispensary, and
   d. The date of acquisition;
3. For acquiring medical marijuana or a marijuana product from another dispensary or a marijuana establishment:
   a. A description of the medical marijuana or marijuana product acquired including:
      i. The amount, batch number, and strain of the medical marijuana or marijuana product;
ii. For a marijuana product, the ingredients in order of abundance; and

iii. For an edible marijuana product infused with medical marijuana or a marijuana product:

1. The date of manufacture,
2. The total weight of the edible marijuana product, and
3. The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible marijuana product;

b. As applicable, either:
   i. The name and registry identification number of the dispensary providing the medical marijuana or marijuana product, or
   ii. The name and license number of the marijuana establishment providing the medical marijuana or marijuana product;

c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent providing the medical marijuana or marijuana product;

d. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent receiving the medical marijuana or marijuana product on behalf of the dispensary; and

e. The date of acquisition;

4. For each batch of marijuana cultivated:
   a. The batch number;
   b. Whether the batch originated from marijuana seeds or marijuana cuttings;
   c. The origin and strain of the marijuana seeds or marijuana cuttings planted;
   d. The number of marijuana seeds or marijuana cuttings planted;
   e. The date the marijuana seeds or cuttings were planted;
   f. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers used in the cultivation;
   g. The number of plants grown to maturity; and
   h. Harvest information including:
      i. Date of harvest,
      ii. Final processed usable marijuana yield weight, and
      iii. Name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent
responsible for the harvest;

5. For providing medical marijuana or a marijuana product to another dispensary or a marijuana establishment:
   a. A description of the medical marijuana or marijuana product provided including:
      i. The amount, batch number, and strain of the medical marijuana or marijuana product;
      ii. For a marijuana product, the ingredients in order of abundance; and
      iii. For an edible marijuana product infused with medical marijuana or a marijuana product:
         (1) The date of manufacture,
         (2) The total weight of the edible marijuana product, and
         (3) The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible marijuana product;
   b. The name and registry identification number or marijuana establishment license number, as applicable, of the other dispensary or the marijuana establishment;
   c. The name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent who received the medical marijuana or marijuana product on behalf of the other dispensary or the marijuana establishment; and
   d. The date the medical marijuana or marijuana product was provided;

6. For submitting marijuana or marijuana products to a laboratory agent or laboratory for testing:
   a. The amount, strain, and batch number of the marijuana or marijuana product submitted;
   b. The name and registry identification number of the laboratory;
   c. The name and registry identification number of the laboratory agent who received the marijuana or marijuana product on behalf of the laboratory; and
   d. The date the marijuana or marijuana product was submitted to the laboratory; and

7. For disposal of medical marijuana or a marijuana product that is not to be dispensed or used for making a marijuana product:
   a. Description of and reason for the medical marijuana or marijuana product being disposed of including, if applicable:
      i. The number of failed or other unusable plants, and
ii. The results of laboratory testing;

b. Date of disposal;

c. Method of disposal; and

d. Name and registry identification number or license number, as applicable, of the dispensary agent or marijuana facility agent responsible for the disposal.

D. The individual designated in subsection (A) shall conduct and document an audit of the dispensary’s inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.

1. If the audit identifies a reduction in the amount of medical marijuana or a marijuana product in the dispensary’s inventory not due to documented causes, the dispensary shall determine and document where the loss has occurred and take and document corrective action.

2. If the reduction in the amount of medical marijuana or a marijuana product in the dispensary’s inventory is due to suspected criminal activity by a dispensary agent or marijuana facility agent, the dispensary shall report the dispensary agent or marijuana facility agent to the Department and to the local law enforcement authorities.

E. A dispensary shall:

1. Maintain the documentation required in subsections (C) and (D) at the dispensary for at least five years after the date on the document, and

2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

R9-17-317.01. Analysis of Medical Marijuana or a Marijuana Product

A. Before offering a batch of medical marijuana or of a marijuana product for sale or dispensing to a qualifying patient or designated caregiver, a dispensary shall ensure that:

1. Except as provided in subsection (A)(2) or (3), each batch of medical marijuana or marijuana product is tested in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1; and

2. Each batch of a marijuana product is tested according to requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 for, as applicable:

   a. At least potency and microbial contaminants other than mycotoxins if the marijuana product was prepared from another marijuana product, such as a concentrate or tincture, that is in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, using none of the following:

      i. A temperature above which any analyte could chemically decompose or
react with a component of the marijuana product;

ii. A pressure above which any analyte could chemically decompose or react with a component of the marijuana product;

iii. A process by which any analyte in the marijuana product that is in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 may be further concentrated; or

iv. A solvent other than water; or

b. All analytes except ethanol if the marijuana product is intended to contain ethanol; and

3. If the results of testing of the dispensary’s medical marijuana and marijuana products for heavy metals, according to R9-17-404.03, indicate that the medical marijuana and marijuana products are in compliance with Table 3.1 for a period of at least six consecutive months:

a. Each batch of medical marijuana or a marijuana product is tested according to requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 for all analytes except heavy metals; and

b. At least once every three months, each batch of medical marijuana or a marijuana product is tested according to requirements in R9-17-404.03 and Table 3.1 for heavy metals.

B. A dispensary shall ensure that:

1. Until laboratory testing has been completed and testing results received by the dispensary that comply with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, a batch of marijuana or of a marijuana product is stored in a location away from medical marijuana and marijuana products offered for dispensing;

2. Only Except as provided in subsection (D), only one sample of each batch of medical marijuana or marijuana product is collected according to ANSI/ASQ Standard Z1.4 (2018), General Inspection Level II, incorporated by reference, including no future editions, and available at https://asq.org/quality-resources/z14-z19, including:

a. Use, as applicable, of one of the following sampling methods:

i. Top, middle, and bottom sampling using a sample thief, a device consisting of two nested tubes with one or more aligned slots through which a sample may be collected and then sealed into the inner tube by rotating the outer tube;

ii. Star pattern sampling from the top, middle, and bottom of each storage
container;

iii. Collecting discrete incremental units of a batch, such as every tenth unit or every twentieth drop; or

iv. Quartering until the sample reaches the size specified in subsection (B)(3); and

b. For sampling methods specified in subsections (B)(2)(a)(i) through (iii), quartering the volume of the aggregated portions collected to obtain the sample size specified in subsection (B)(3);

3. The size of the sample provided to a laboratory is sufficient for testing and, if necessary, retesting;

4. Each sample in subsection (B)(3) is packaged in a container made of:
   a. The same material that would be used for dispensing, or
   b. Another material that will not react with or leach into the sample;

5. Each packaged sample is labeled with the:
   a. The dispensary’s registry identification number;
   b. The amount, strain, and batch number of the medical marijuana or marijuana product;
   c. The storage temperature for the medical marijuana or marijuana product; and
   d. The date of sampling;

6. A packaged sample in subsection (B)(4) is submitted to a laboratory that:
   a. Has a laboratory registration certificate issued by the Department, and
   b. Is approved for testing by the Department for an analyte for which testing is being requested;

7. Except as specified in subsections (A)(2) and (C)(1) or (3)(b), as applicable, the samples in subsection (B)(4) are tested for each analyte specified in Table 3.1 by a laboratory that is approved by the Department for testing the analyte;

8. Only batches of marijuana or marijuana products for which laboratory testing results in subsection (B)(7) are in compliance with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 are offered for sale or dispensing; and

9. Except as provided in subsection (C), any batch of marijuana or marijuana product that does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 is remediated, if applicable, or destroyed according to policies and procedures.

C. If a dispensary receives a final report of testing, specified in R9-17-404.06(B)(3), from a laboratory that indicates that a batch of medical marijuana or marijuana product does not comply
with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, the dispensary:

1. Within seven days after receiving the final report of testing, may request retesting of the remaining portion of the sample in subsection (B)(4) for all analytes that do not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 by a second, independent laboratory that is approved by the Department for testing the analytes;

2. If the final report of testing from the second, independent laboratory indicates that any analyte tested for according to subsection (C)(1) does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, shall remediate, if applicable, or destroy the batch of medical marijuana or marijuana product according to policies and procedures;

3. If the final report of testing from the second, independent laboratory indicates that all analytes tested for according to subsection (C)(1) comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1:
   a. Shall ensure that the batch of medical marijuana or marijuana product is not offered for sale or dispensing; and
   b. May request retesting of the remaining portion of the sample in subsection (B)(4) for the analytes that do not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 by a third, independent laboratory that is approved by the Department for testing the analytes; and

4. If the dispensary requested retesting of the remaining portion of the sample in subsection (B)(4) for an analyte by a third, independent laboratory according to subsection (C)(3)(b):
   a. If the final report of testing from the third, independent laboratory indicates that the analyte tested for according to subsection (C)(3) complies with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, may offer the batch of medical marijuana or marijuana product for sale or dispensing; and
   b. If the final report of testing from the third, independent laboratory indicates that an analyte tested for according to subsection (C)(3) does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1, shall remediate, if applicable, or destroy the batch of medical marijuana or marijuana product according to policies and procedures.

D. A dispensary may request retesting of a batch of medical marijuana or marijuana product using a second sample if:

1. The batch of marijuana or marijuana product is still in the possession of the dispensary;
2. The dispensary receives notification from the Department or another dispensary that
indicates that the final report of testing from a laboratory, specified in R9-17-404.06(B)(3), for the batch of medical marijuana or marijuana product may be inaccurate;

3. The dispensary:
   a. Collects the second sample according to subsections (B)(2) and (3);
   b. Packages and labels the sample according to subsections (B)(4) and (5); and
   c. Submits the sample to a second, independent laboratory that is approved by the Department for testing the analytes; and

4. The dispensary follows the requirements in subsections (C)(2) through (4) in determining whether the batch of medical marijuana or marijuana product:
   a. May be offered for sale or dispensing, or
   b. Is required to be remediated, if applicable, or destroyed.

D.E. A dispensary shall ensure that remediation of a batch of marijuana or of a marijuana product that has undergone laboratory testing and does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1:
   1. Is performed according to policies and procedures,
   2. Uses a method that is appropriate to address an analyte not in compliance with Table 3.1, and
   3. Does not introduce or produce a substance in a concentration that is known to be harmful to humans.

E.F. If a batch of medical marijuana or a marijuana product is remediated, a dispensary shall submit samples from the remediated batch for laboratory testing according to subsection (B).

F.G. A dispensary shall provide to the Department upon request a sample of the dispensary’s inventory of medical marijuana or a marijuana product of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana or marijuana product.
Table 3.1. Analytes

Key:
- CAS Number = Chemical Abstract Services Registry number
- CFU = Colony-forming unit, a method to estimate the number of viable bacteria or fungal cells in a sample
- * = Testing for the analyte required beginning May 1, 2021. Required for marijuana products only

A. Microbial Contaminants

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Contaminants</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Escherichia coli</em></td>
<td>100 CFU/g</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td><em>Salmonella spp.</em></td>
<td>Detectable in 1 gram</td>
<td>Destroy</td>
</tr>
<tr>
<td><em>Aspergillus flavus</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Aspergillus fumigatus</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Aspergillus niger</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Aspergillus terreus</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Mycotoxins:</em> Aflatoxin B1, B2, G1, and G2</td>
<td>Marijuana product, except a marijuana product intended for topical application, prepared from an extract or concentrate of medical marijuana: 20 µg/kg (ppb) of total aflatoxins 20 µg/kg (ppb) of ochratoxin</td>
<td>Destroy</td>
</tr>
<tr>
<td>Ochratoxin A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Heavy Metals

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arsenic</td>
<td>0.4 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td>Cadmium</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Lead</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Mercury</td>
<td>1.2 ppm</td>
<td></td>
</tr>
</tbody>
</table>

C. *Residual Solvents

<table>
<thead>
<tr>
<th>Analyte</th>
<th>CAS Number</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>67-64-1</td>
<td>1,000 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td>Acetonitrile</td>
<td>75-05-8</td>
<td>410 ppm</td>
<td></td>
</tr>
<tr>
<td>Benzene</td>
<td>71-43-2</td>
<td>2 ppm</td>
<td></td>
</tr>
<tr>
<td>Butanes (measured as the cumulative residue of n-butane and iso-butane)</td>
<td>106-97-8 and 75-28-5, respectively</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Chloroform</td>
<td>67-66-3</td>
<td>60 ppm</td>
<td></td>
</tr>
<tr>
<td>Dichloromethane</td>
<td>75-09-2</td>
<td>600 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethanol</td>
<td>64-17-5</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethyl Acetate</td>
<td>141-78-6</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethyl Ether</td>
<td>60-29-7</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Heptane</td>
<td>142-82-5</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Hexanes (measured as the)</td>
<td>110-54-3, 107-83-5,</td>
<td>290 ppm</td>
<td></td>
</tr>
</tbody>
</table>
cumulative residue of n-hexane, 2-methylpentane, 3-methylpentane, 2,2-dimethylbutane, and 2,3-dimethylbutane) 96-14-0, 75-83-2, and 79-29-8, respectively

<table>
<thead>
<tr>
<th>Analyte</th>
<th>CAS Number</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isopropyl Acetate</td>
<td>108-21-4</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Methanol</td>
<td>67-56-1</td>
<td>3,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Pentanes (measured as the cumulative residue of n-pentane, iso-pentane, and neo-pentane) 109-66-0, 78-78-4, and 463-82-1, respectively</td>
<td>5,000 ppm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-Propanol (IPA)</td>
<td>67-63-0</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Propane</td>
<td>74-98-6</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Toluene</td>
<td>108-88-3</td>
<td>890 ppm</td>
<td></td>
</tr>
<tr>
<td>Xylenes (measured as the cumulative residue of 1,2-dimethylbenzene, 1,3-dimethylbenzene, and 1,4-dimethylbenzene, and the non-xylene, ethyl benzene) 1330-20-7 (95-47-6, 108-38-3, and 106-42-3, respectively, and 100-41-4)</td>
<td>2,170 ppm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Pesticides, Fungicides, Growth Regulators

<table>
<thead>
<tr>
<th>Analyte</th>
<th>CAS Number</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Abamectin</td>
<td>71751-41-2</td>
<td>0.5 ppm</td>
<td>Remedierte and retest, or Destroy</td>
</tr>
<tr>
<td>Acephate</td>
<td>30560-19-1</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Acequinocyl</td>
<td>57960-19-7</td>
<td>2.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Acetamiprid</td>
<td>135410-20-7</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Aldicarb</td>
<td>116-06-3</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Azauxystrobin</td>
<td>131860-33-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Bifenazate</td>
<td>149877-41-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Bifenthrin</td>
<td>82657-04-3</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Boscalid</td>
<td>188425-85-6</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Carbaryl</td>
<td>63-25-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Carbofuran</td>
<td>1563-66-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Chlorantraniliprole</td>
<td>500008-45-7</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Chlorfenapyr</td>
<td>122453-73-0</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Chlorpyrifos</td>
<td>2921-88-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Clofentezine</td>
<td>74115-24-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Cyfluthrin</td>
<td>68359-37-5</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Cypermethrin</td>
<td>52315-07-8</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Daminozide</td>
<td>1596-84-5</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*DDVP (Dichlorvos)</td>
<td>62-73-7</td>
<td>0.1 ppm</td>
<td></td>
</tr>
<tr>
<td>Diazinon</td>
<td>333-41-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Dimethoate</td>
<td>60-51-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethoprophos</td>
<td>13194-48-4</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Etofenprox</td>
<td>80844-07-1</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Etoxazole</td>
<td>153233-91-1</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Fenoxycarb</td>
<td>72490-01-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Fenpyroximate</td>
<td>134098-61-6</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>*Fipronil</td>
<td>120068-37-3</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Analyte</td>
<td>Labelling</td>
<td>Required Action</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tetrahydrocannabinolic acid (THC-A)</td>
<td>Label claim is not within +/- 20% of tested value</td>
<td>Revise label as necessary</td>
<td></td>
</tr>
<tr>
<td>Delta-9-tetrahydrocannabinol (Δ9-THC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabidiolic acid (CBD-A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabidiol (CBD)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**E. Potency**

**F. Herbicides**

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum-Allowable-Contaminant</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendimethalin</td>
<td>0.1 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
</tbody>
</table>
R9-17-319. Edible Food Products

A. A dispensary that prepares, sells, or dispenses marijuana-infused edible food products shall:
   1. Before preparing, selling, or dispensing marijuana-infused edible food products, obtain written authorization from the Department a license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, to prepare, sell, or dispense marijuana-infused edible food products;
   2. If the dispensary prepares the marijuana-infused edible food products, ensure that the marijuana-infused edible food products are prepared according to the applicable requirements in 9 A.A.C. 8, Article 1;
   3. If the marijuana-infused edible food products are not prepared at the dispensary, obtain and maintain at the dispensary a copy of the current written authorization license or permit as a food establishment, issued under 9 A.A.C. 8, Article 1, to prepare marijuana-infused edible food products from the dispensary or marijuana establishment that prepares the marijuana-infused edible products;
   4. Before selling or dispensing marijuana-infused edible food products, obtain a license or permit of the location as a food establishment, issued under 9 A.A.C. 8, Article 1, to sell or dispense marijuana-infused edible food products that are either:
      a. A time/temperature control for safety food, or
      b. Not prepared in individually packaged containers; and
   4.5 If a dispensary sells or dispenses marijuana-infused edible food products, ensure that the marijuana-infused edible food products are sold or dispensed according to applicable requirements in 9 A.A.C. 8, Article 1.

B. A dispensary is responsible for the content and quality of any edible food product sold or dispensed by the dispensary.

R9-17-322. Denial or Revocation of a Dispensary Registration Certificate

A. The Department shall deny an application for a dispensary registration certificate or a renewal if:
   1. For an application for a dispensary registration certificate, the physical address of the building or, if applicable, the physical address of the dispensary’s cultivation site is within 500 feet of a private school or a public school that existed before the date the dispensary submitted the initial dispensary registration certificate application, before the date of an application to change the location of the dispensary, or before the date of an application to add a cultivation site;
   2. A principal officer or board member:
      a. Has been convicted of an excluded felony offense;
b. Has served as a principal officer or board member for a dispensary or marijuana establishment that:
   i. Had the dispensary registration certificate or marijuana establishment license revoked, or
   ii. Did not obtain an approval to operate the dispensary or marijuana establishment, as applicable, within the first year 18 months after the dispensary registration certificate or marijuana establishment license was issued;

c. Is under 21 years of age; or
d. Is a physician currently providing written certifications for medical marijuana for qualifying patients; or
e. Is a law enforcement officer; or
f. Is an employee or contractor of the Department; or

3. The application or the dispensary does not comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter.

B. The Department may deny an application for a dispensary registration certificate if a principal officer or board member of the dispensary provides false or misleading information to the Department.

C. The Department shall revoke a dispensary’s registration certificate if:
   1. The dispensary:
      a. Operates before obtaining approval to operate a dispensary from the Department;
      b. Diverts marijuana to an entity a person other than:
         i. Another dispensary with a valid dispensary registration certificate issued by the Department,
         ii. A marijuana establishment with a valid marijuana establishment license issued under 9 A.A.C. 18;
         iii. A laboratory with a valid laboratory registration certificate issued by the Department,
         iv. A qualifying patient with a valid registry identification card issued by the Department,
         v. A designated caregiver with a valid registry identification card issued by the Department,
         vi. A dispensary agent with a valid registry identification card or marijuana facility agent with a valid marijuana facility agent license issued by the
Department accepting the marijuana on behalf of a dispensary or marijuana establishment, or
vi. vii. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory;

c. Acquires usable marijuana or mature marijuana plants from any entity other than another dispensary with a valid dispensary registration certificate issued by the Department, a marijuana establishment with a marijuana establishment license issued under 9 A.A.C. 18, a qualifying patient with a valid registry identification card, or a designated caregiver with a valid registry identification card; or
d. Acquires a marijuana product from any person other than another dispensary with a valid dispensary registration certificate issued by the Department or a marijuana establishment with a marijuana establishment license issued under 9 A.A.C. 18; or

2. A principal officer or board member has been convicted of an excluded felony offense.

D. The Department may revoke a dispensary registration certificate if the dispensary does not:
1. Comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter; or
2. Implement the policies and procedures or comply with the statements provided to the Department with the dispensary’s application.

E. If the Department denies a dispensary registration certificate application, the Department shall provide notice to the applicant that includes:
1. The specific reason or reasons for the denial, and
2. All other information required by A.R.S. § 41-1076.

F. If the Department revokes a dispensary registration certificate, the Department shall provide notice to the dispensary that includes:
1. The specific reason or reasons for the revocation; and
2. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

R9-17-323. Denial or Revocation of a Dispensary Agent’s Registry Identification Card

A. The Department shall deny a dispensary agent’s application for or renewal of the dispensary agent’s registry identification card if the dispensary agent:
1. Does not meet the definition “nonprofit medical marijuana dispensary agent” in A.R.S. § 36-2801; or
2. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
3. Previously had a marijuana facility agent license revoked for not complying with A.R.S. Title 36, Chapter 28.2 or 9 A.A.C. 18.

B. The Department may deny a dispensary agent’s application for or renewal of the dispensary agent’s registry identification card if the dispensary agent provides false or misleading information to the Department.

C. The Department shall revoke a dispensary agent’s registry identification card if the dispensary agent:
   1. Uses medical marijuana, if the dispensary agent does not have a qualifying patient registry identification card;
   2. Diverts medical marijuana to an entity a person other than:
      a. Another dispensary with a valid dispensary registration certificate issued by the Department,
      b. A marijuana establishment with a valid marijuana establishment license issued under 9 A.A.C. 18;
      c. A laboratory with a valid laboratory registration certificate issued by the Department,
      d. A qualifying patient with a valid registry identification card issued by the Department,
      e. A designated caregiver with a valid registry identification card issued by the Department,
      f. A dispensary agent with a valid registry identification card or marijuana facility agent with a valid marijuana facility agent license issued by the Department accepting the marijuana on behalf of a dispensary or marijuana establishment, or
      g. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory; or
   3. Has Except as provided in A.R.S. § 36-2804.01(D), has been convicted of an excluded felony offense.

D. The Department may revoke a dispensary agent’s registry identification card if the dispensary agent knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.

E. If the Department denies or revokes a dispensary agent’s registry identification card, the Department shall provide notice to the dispensary agent and the dispensary agent’s dispensary that includes:
   1. The specific reason or reasons for the denial or revocation; and
   2. The process for requesting a judicial review of the Department’s decision pursuant to
A.R.S. Title 12, Chapter 7, Article 6.

R9-17-324. Dual Licensees

A. If a dispensary is a dual licensee, the dispensary shall:
   1. Provide marijuana and marijuana products, according to A.A.C. R9-18-309, to consumers, as defined in A.R.S. § 36-2850, at the same location as the dispensary dispenses medical marijuana and marijuana products to qualifying patients and designated caregivers;
   2. Notify the Department within five calendar days after beginning to operate on a for-profit basis, as allowed by A.R.S. § 36-2858(D)(2), and, if applicable, provide to the Department the documents required in R9-17-304(C)(2) for the new organizational or corporate structure; and
   3. Comply with the requirements in A.R.S. § 36-2858(D)(3).

B. If a dispensary is a dual licensee, the entity holding the valid dispensary registration certificate may:
   1. Request that the dispensary’s cultivation site, specified according to R9-17-305(A)(1)(e) or R9-17-307(A)(1), be transferred under the entity’s marijuana establishment license according to A.A.C. R9-18-303(E)(3);
   2. Request approval of a change in the location in subsection (A)(1) by complying with the requirements in both:
      a. R9-17-307(A), and
      b. A.A.C. R9-18-306; or
   3. Transfer or assign both the dispensary registration certificate and the marijuana establishment license to the same entity.

C. A dispensary that is a dual licensee may allow an individual without a dispensary agent registry identification card or marijuana facility agent license to be employed by or contracted with the dispensary and into areas of the dispensary or the dispensary’s cultivation site where marijuana is cultivated, processed, manufactured, or stored if:
   1. The individual has a marijuana facility agent license, issued under 9 A.A.C. 18, Article 2, associated with the entity holding the dispensary’s dispensary registration certificate and marijuana establishment license; or
   2. The individual:
      a. Is not at the dispensary or the dispensary’s cultivation site more than once per week; and
      b. When at the dispensary or the dispensary’s cultivation site, is supervised by a dispensary agent who has a valid registry identification card or an individual in subsection (C)(1)
with a valid marijuana facility license associated with the dispensary.

D. A dispensary that is a dual licensee is exempt from the requirements in:
   1. R9-17-310(A)(5), (12), and (13);
   2. R9-17-313; and
   3. R9-17-320(B)(4) and (5), but shall ensure that a dispensary agent or marijuana facility agent at the dispensary or the dispensary’s cultivation site:
      a. Reports to a principal officer or board member of the dispensary any health condition experienced by the dispensary agent or marijuana facility agent that may adversely affect the safety or quality of any medical marijuana or marijuana products with which the dispensary agent or marijuana facility agent may come into contact; and
      b. If the principal officer or board member determines that a dispensary agent or marijuana facility agent has a health condition that may adversely affect the safety or quality of the medical marijuana or marijuana products, is prohibited from direct contact with any medical marijuana, marijuana products, or equipment or materials for processing medical marijuana or marijuana products until the principal officer or board member determines that the dispensary agent’s or marijuana facility agent’s health condition will not adversely affect the medical marijuana or marijuana products.

E. A dispensary that is a dual licensee:
   1. If the dispensary has notified the Department according to subsection (A)(2) that the dispensary has begun operating on a for-profit basis and provided a valid marijuana establishment license number according to R9-18-308(1)(c), is exempt from the requirements in R9-18-308(3); and
   2. If the dispensary is still operating on a not-for-profit basis and provided a valid marijuana establishment license number according to R9-18-308(1)(c), may submit to the Department when renewing the dispensary’s dispensary registration certificate an attestation, in a Department-provided format, that the dispensary is operating on a not-for-profit basis in lieu of submitting the copy of an annual financial statement required in R9-18-308(3)(a) and the report of an audit required in R9-18-308(3)(b).

F.F. If the Department identifies an instance of noncompliance with a requirement of both this Chapter and 9 A.A.C. 18 during an inspection of a dual licensee, the Department shall note the instance of noncompliance on a notice of deficiencies associated with the dual licensee’s marijuana establishment license under 9 A.A.C. 18, rather than on both the notice of deficiencies for the
dispensary registration certificate and the notice of deficiencies for the marijuana establishment license.
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ARTICLE 1. GENERAL

R9-17-101. Definitions

In addition to the definitions in A.R.S. § 36-2801, the following definitions apply in this Chapter unless otherwise stated:

1. “Accreditation” means being deemed as technically competent under ISO 17025 by the:
   a. American Association of Laboratory Accreditation,
   b. Perry Johnson Laboratory Accreditation,
   c. ANSI National Accreditation Board, or
   d. International Accreditation Services.

2. “Accuracy testing” means a mechanism in which a laboratory performs testing on samples with known characteristics, prepared by the laboratory, to determine a laboratory agent’s ability to analyze samples within specific acceptance criteria.

3. “Acquire” means to obtain through any type of transaction and from any source.

4. “Activities of daily living” means ambulating, bathing, dressing, grooming, eating, toileting, and getting in and out of bed.

5. “Amend” means adding or deleting information on an individual’s registry identification card that affects the individual’s ability to perform or delegate a specific act or function.

6. “Analyte” means a specific substance for which testing is performed by a laboratory.

7. “Applicant” means:
   a. An individual submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent;
   b. An entity submitting an application for a dispensary registration certificate or approval to operate a dispensary; or
   c. An individual or entity submitting an application for a laboratory registration certificate, approval to test, or approval to change parameters.

8. “Batch” means:
   a. When referring to cultivated medical marijuana, a specific lot of medical marijuana grown from one or more seeds or cuttings that are planted and harvested at the same time;
   b. When referring to marijuana products, a specific amount of a marijuana product infused, manufactured, or prepared for sale from the same set of ingredients at the same time; and
   c. When referring to testing of medical marijuana or a marijuana product, a specific set of samples prepared and tested during the same run using the same equipment.
9. “Batch number” means a unique numeric or alphanumeric identifier assigned to a batch by a dispensary when:
   a. The batch of medical marijuana is planted, or
   b. The batch of a marijuana product is infused, manufactured, or prepared for sale.

10. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

11. “Change” means:
   a. When used in relation to a registry identification card, adding or deleting information on an individual’s registry identification card that does not substantively affect the individual’s ability to perform or delegate a specific act or function;
   b. When used in relation to a place, moving to a different location;
   c. When used in relation to an individual, selecting a different individual to perform specific actions;
   d. When used in relation to parameters, revising a laboratory’s standard operating procedures or quality assurance plan, required in R9-17-404.06, due to:
      i. Adding or removing a parameter,
      ii. Altering a testing method, or
      iii. Using a different instrument for performing a test; and
   e. When used in relation to testing results, altering the testing results in any way and for any reason.

12. “Commercial device” means the same as in A.R.S. § 3-3451.

13. “Contaminant” means matter, pollutant, hazardous substance, or other substance that is not intended to be part of dispensed medical marijuana or a marijuana product.

14. “Cultivation site” means the one additional location where marijuana may be cultivated, infused, or prepared for sale by and for a dispensary.

15. “Current photograph” means an image of an individual, taken no more than 60 calendar days before the submission of the individual’s application, in a Department-approved electronic format capable of producing an image that:
   a. Has a resolution of at least 600 x 600 pixels but not more than 1200 x 1200 pixels;
   b. Is 2 inches by 2 inches in size;
   c. Is in natural color;
d. Is a front view of the individual’s full face, without a hat or headgear that obscures the hair or hairline;

e. Has a plain white or off-white background; and

f. Has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head.

16. “Denial” means the Department’s final decision not to issue a registry identification card, a dispensary registration certificate, a laboratory registration certificate, or an approval of a change of dispensary or a dispensary’s cultivation site location, to an applicant because the applicant or the application does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.

17. “Dispensary” means the same as “nonprofit medical marijuana dispensary” as defined in A.R.S. § 36-2801.

18. “Dispensary agent” means the same as “nonprofit medical marijuana dispensary agent” as defined in A.R.S. § 36-2801.


20. “Edible food product” means a substance, beverage, or ingredient used or intended for use or for sale in whole or in part for human oral consumption.

21. “Enclosed area” when used in conjunction with “enclosed, locked facility” means outdoor space surrounded by solid, 10-foot walls, constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, and a 1-inch thick metal gate.

22. “Entity” means the same as in A.R.S. § 29-2102.

23. “Generally accepted accounting principles” means the set of financial reporting standards established by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or another specialized body dealing with accounting and auditing matters.

24. “Geographic area” means the same as in A.R.S. § 36-2803.01.


26. “Inhalable” means intended for use through intake into the lungs of an individual.

27. “Laboratory” means the same as “independent third-party laboratory” as defined in A.R.S. § 36-2801.

28. “Laboratory agent” means the same as “independent third-party laboratory agent” as defined in A.R.S. § 36-2801.

29. “Legal guardian” means an adult who is responsible for a minor:

   a. Through acceptance of guardianship of the minor through a testamentary appointment or an appointment by a court pursuant to A.R.S. Title 14, Chapter 5, Article 2; or

   b. As a “custodian” as defined in A.R.S. § 8-201.
30. “Marijuana establishment” means the same as in A.R.S. § 36-2850.
31. “Medical record” means the same as:
   a. “Adequate records” as defined in A.R.S. § 32-1401,
   b. “Adequate medical records” as defined in A.R.S. § 32-1501,
   c. “Adequate records” as defined in A.R.S. § 32-1800, or
   d. “Adequate records” as defined in A.R.S. § 32-2901.
33. “Parameter” means the combination of a particular type of sample with a specific instrument or equipment by which the sample will be tested for a specific analyte or characteristic.
34. “Proficiency testing” means a mechanism in which samples with known characteristics are submitted to a laboratory for analysis to determine a laboratory agent’s ability to analyze samples within specific acceptance criteria.
35. “Proficiency testing service” means an independent company or other person acceptable to the Department, based on ISO/IEC 17043:2010 certification, that:
   a. Is the source for samples with known characteristics for proficiency testing, and
   b. Assesses the acceptability of a laboratory agent’s results from the samples with known characteristics during proficiency testing.
37. “Public place”:
   a. Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or a specific group of individuals;
   b. Includes, but not is limited to:
      i. Airports;
      ii. Banks;
      iii. Bars;
      iv. Child care facilities;
      v. Child care group homes during hours of operation;
      vi. Common areas of apartment buildings, condominiums, or other multifamily housing facilities;
      vii. Educational facilities;
      viii. Entertainment facilities or venues;
      ix. Health care institutions, except as provided in subsection (37)(c);
      x. Hotel and motel common areas;
      xi. Laundromats;
xii. Libraries;

xiii. Office buildings;

xiv. Parking lots;

xv. Parks;

xvi. Public transportation facilities;

xvii. Reception areas;

xviii. Restaurants;

xix. Retail food production or marketing establishments;

xx. Retail service establishments;

xxi. Retail stores;

xxii. Shopping malls;

xxiii. Sidewalks;

xxiv. Sports facilities;

xxv. Theaters; and

xxvi. Waiting rooms; and

c. Does not include:

i. Nursing care institutions as defined in A.R.S. § 36-401,

ii. Hospices as defined in A.R.S. § 36-401,

iii. Assisted living centers as defined in A.R.S. § 36-401,

iv. Assisted living homes as defined in A.R.S. § 36-401,

v. Adult day health care facilities as defined in A.R.S. § 36-401,

vi. Adult foster care homes as defined in A.R.S. § 36-401, or

vii. Private residences.

38. “Public school” means the same as “school” as defined in A.R.S. § 15-101.

39. “Registry identification number” means the random 20-digit alphanumeric identifier generated by the Department, containing at least four numbers and four letters, issued by the Department to a qualifying patient, designated caregiver, dispensary, dispensary agent, laboratory, or laboratory agent.

40. “Revocation” means the Department’s final decision that an individual’s registry identification card, a dispensary registration certificate, or a laboratory registration certificate is rescinded because the individual, the dispensary, or the laboratory does not comply with the applicable requirements in A.R.S. Title 36, Chapter 28.1 or this Chapter.

41. “Sample” means:

a. A representative portion of a larger quantity of medical marijuana or a marijuana product,
b. A specific quantity of a substance or set of substances to be used for testing purposes, or
c. To collect the representative portion in subsection (41)(a).

42. “Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a statewide furlough day.

R9-17-102. Fees
A. An applicant submitting an application to the Department shall submit the following nonrefundable fees:
   1. Except as provided in R9-17-303(D), for registration of a dispensary, $5,000;
   2. To renew the registration of a dispensary, $1,000;
   3. To change the location of a dispensary, $2,500;
   4. To change the location of a dispensary’s cultivation site or add a cultivation site, $2,500;
   5. For a registry identification card for a:
      a. Qualifying patient, except as provided in subsection (B), $150;
      b. Designated caregiver, $200;
      c. Dispensary agent, $500; and
      d. Laboratory agent, $500;
   6. For renewing a registry identification card for a:
      a. Qualifying patient, except as provided in subsection (B), $150;
      b. Designated caregiver, $200;
      c. Dispensary agent, $500; and
      d. Laboratory agent, $500;
   7. For amending or changing a registry identification card, $10;
   8. For requesting a replacement registry identification card, $10;
   9. For registration of a laboratory, $5,000; and
   10. To renew the registration of a laboratory, $1,000.
B. A qualifying patient may pay a reduced fee of $75 if the qualifying patient submits, with the qualifying patient’s application for a registry identification card or the qualifying patient’s application to renew the qualifying patient’s registry identification card, a copy of an eligibility notice or electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture, Food and Nutrition Services, Supplemental Nutrition Assistance Program.

R9-17-103. Application Submission
A. An applicant submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, dispensary agent, or laboratory agent, shall submit the application electronically in a Department-provided format.

B. A residence address or mailing address submitted for a qualifying patient or designated caregiver as part of an application for a registry identification card is located in Arizona.

C. A mailing address submitted for a principal officer or board member as part of a dispensary certificate registration application or as part of an application for a dispensary agent registration identification card is located in Arizona.

D. A mailing address submitted for an owner as a part of a laboratory registration certificate application or as part of an application for a laboratory agent registration identification card is located in Arizona.

R9-17-104. Changing Information on a Registry Identification Card
Except as provided in R9-17-203(B) and (C), to make a change to a cardholder’s name or address on the cardholder’s registry identification card, the cardholder shall submit to the Department, within 10 working days after the change, a request for the change that includes:

1. The cardholder’s name and the registry identification number on the cardholder’s current registry identification card;
2. The cardholder’s new name or address, as applicable;
3. For a change in the cardholder’s name, one of the following with the cardholder’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the cardholder’s U.S. passport;
4. For a change in address, the county where the new address is located;
5. The effective date of the cardholder’s new name or address; and
6. The applicable fee in R9-17-102 for changing a registry identification card.

R9-17-105. Requesting a Replacement Registry Identification Card
To request a replacement card for a cardholder’s registry identification card that has been lost, stolen, or destroyed, the cardholder shall submit to the Department, within 10 working days after the cardholder’s registry identification card was lost, stolen, or destroyed, a request for a replacement card that includes:

1. The cardholder’s name and date of birth;
2. If known, the registry identification number on the cardholder’s lost, stolen, or destroyed registry identification card;
3. If the cardholder cannot provide the registry identification number on the cardholder’s lost, stolen, or destroyed registry identification card, a copy of one of the following documents that the cardholder submitted when the cardholder obtained the registry identification card:
   a. Arizona driver’s license,
   b. Arizona identification card,
   c. Arizona registry identification card, or
   d. Photograph page in the cardholder’s U.S. passport; and
4. The applicable fee in R9-17-102 for requesting a replacement registry identification card.

R9-17-106. Adding a Debilitating Medical Condition
A. An entity may request the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 by submitting to the Department, at the times specified in subsection (C), the following in writing:
   1. The entity’s name;
   2. The entity’s mailing address, name of contact individual, telephone number, and, if applicable, e-mail address;
   3. The name of the medical condition the entity is requesting be added;
   4. A description of the symptoms and other physiological effects experienced by an individual suffering from the medical condition or a treatment of the medical condition that may impair the ability of the individual to accomplish activities of daily living;
   5. The availability of conventional medical treatments to provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition;
   6. A summary of the evidence that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or a treatment of the medical condition; and
   7. Articles, published in peer-reviewed scientific journals, reporting the results of research on the effects of marijuana on the medical condition or a treatment of the medical condition supporting why the medical condition should be added.

B. The Department shall:
   1. Acknowledge in writing the Department’s receipt of a request for the addition of a medical condition to the list of debilitating medical conditions listed in R9-17-201 within 30 calendar days after receiving the request;
   2. Review the request to determine if the requester has provided evidence that:
      a. The specified medical condition or treatment of the medical condition impairs the ability of the individual to accomplish activities of daily living, and
b. Marijuana usage provides a therapeutic or palliative benefit to an individual suffering from the medical condition or treatment of the medical condition;

3. Within 90 calendar days after receiving the request, notify the requester that the Department has determined that the information provided by the requester:
   a. Meets the requirements in subsection (B)(2) and the date the Department will conduct a public hearing to discuss the request; or
   b. Does not meet the requirements in subsection (B)(2), the specific reason for the determination, and the process for requesting judicial review of the Department’s determination pursuant to A.R.S. Title 12, Chapter 7, Article 6;

4. If applicable:
   a. Schedule a public hearing to discuss the request;
   b. Provide public notice of the public hearing by submitting a Notice of Public Information to the Office of the Secretary of State, for publication in the Arizona Administrative Register at least 30 calendar days before the date of the public hearing;
   c. Post a copy of the request on the Department’s web site for public comment at least 30 calendar days before the date of the public hearing; and
   d. Hold the public hearing no more than 150 calendar days after receiving the request; and

5. Within 180 calendar days after receiving the request:
   a. Add the medical condition to the list of debilitating medical conditions, or
   b. Provide written notice to the requester of the Department’s decision to deny the request that includes:
      i. The specific reasons for the Department’s decision; and
      ii. The process for requesting judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

C. The Department shall accept requests for the addition of a medical condition to the list of debilitating medical conditions in R9-17-201 in January and July of each calendar year starting in January 2012.

R9-17-107. Time-frames

A. Within the administrative completeness review time-frame for each type of approval in Table 1.1, the Department shall:

1. Issue a registry identification card, a dispensary registration certificate, an approval to operate a dispensary, a laboratory registration certificate, an approval for testing, or an approval to add a parameter;
2. Provide a notice of administrative completeness to an applicant; or
3. Provide a notice of deficiencies to an applicant, including a list of the information or documents needed to complete the application.

B. An application for approval to operate a dispensary is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-305 that the dispensary is ready for an inspection by the Department.

C. A laboratory’s application for approval for testing is not complete until the date the applicant states on a written notice provided to the Department according to R9-17-402.01 that the laboratory is ready for an inspection by the Department.

D. If the Department provides a notice of deficiencies to an applicant:
   1. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant; and
   2. The Department shall consider the application withdrawn if the applicant does not submit the missing information or documents to the Department within the time-frame in Table 1.1.

E. Within the substantive review time-frame for each type of approval in Table 1.1, the Department:
   1. According to subsection (H), shall issue or deny:
      a. A registry identification card, dispensary registration certificate, or laboratory registration certificate; or
      b. Approval to operate a dispensary, approval for testing, or approval to add a parameter;
   2. May complete an inspection that may require more than one visit to a dispensary and, if applicable, the dispensary’s cultivation site;
   3. May complete an inspection that may require more than one visit to a laboratory; and
   4. May make one written comprehensive request for more information, unless the Department and the applicant agree in writing to allow the Department to submit supplemental requests for information.

F. If the Department issues a written comprehensive request or a supplemental request for information:
   1. The substantive review time-frame and the overall time-frame are suspended from the date of the written comprehensive request or the supplemental request for information until the date the Department receives all of the information requested, and
   2. The applicant shall submit to the Department all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.

G. If an applicant for an initial dispensary registration certificate is allocated a dispensary registration certificate as provided in R9-17-303, the Department shall provide a written notice to the applicant of
the allocation of the dispensary registration certificate that contains the dispensary’s registry identification number.

1. After the applicant receives the written notice of the allocation, the applicant shall submit to the Department for each principal officer or board member for whom fingerprints were submitted according to R9-17-304(C)(3)(b):

   a. An application for a dispensary agent registry identification card that includes:
      
      i. The principal officer’s or board member’s first name; middle initial, if applicable; last name; and suffix, if applicable;
      
      ii. The principal officer’s or board member’s residence address and mailing address;
      
      iii. The county where the principal officer or board member resides;
      
      iv. The principal officer’s or board member’s date of birth;
      
      v. The identifying number on the applicable card or document in subsection (G)(1)(b)(i) through (v);
      
      vi. The name and registry identification number of the dispensary;
      
   vii. One of the following:
      
      (1) A statement that the principal officer or board member does not currently hold a valid registry identification card, or
      
      (2) The assigned registry identification number for each valid registry identification card currently held by the principal officer or board member;

   viii. A statement signed by the principal officer or board member pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

   ix. An attestation that the information provided in and with the application is true and correct; and

   x. The signature of the principal officer or board member and the date the principal officer or board member signed;

   b. A copy the principal officer’s or board member’s:
      
      i. Arizona driver’s license issued on or after October 1, 1996;
      
      ii. Arizona identification card issued on or after October 1, 1996;
      
      iii. Arizona registry identification card;
      
      iv. Photograph page in the principal officer’s or board member’s U.S. passport; or
      
      v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the principal officer or board member:
         
         (1) Birth certificate verifying U.S. citizenship,
(2) U.S. Certificate of Naturalization, or
(3) U.S. Certificate of Citizenship;
c. A current photograph of the principal officer or board member; and
d. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.

2. After receipt of the information and documents in subsection (G)(1), the Department shall review the information and documents.
   a. If the information and documents for at least one of the principal officers or board members complies with the A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue:
      i. A dispensary agent registry identification card to any principal officer or board member whose dispensary agent registry identification card application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
      ii. The dispensary registration certificate.
   b. If the information and documents for a dispensary agent registry identification card application for any principal officer or board member does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall deny the dispensary agent registry identification card application and provide notice to the principal officer or board member and to the dispensary that includes:
      i. The specific reasons for the denial; and
      ii. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

H. If an application for an initial laboratory registration certificate is approved, the Department shall review the information and documents submitted according to R9-17-402(A)(4) and:
1. If the information and documents for at least one of the owners comply with the A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue:
   a. A laboratory agent registry identification card to any owner who complies with A.R.S. Title 36, Chapter 28.1 and this Chapter; and
   b. The laboratory registration certificate; and
2. If the information and documents submitted according to R9-17-402(A)(4) for an owner do not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall deny the owner a laboratory agent registry identification card and provide notice to the owner and to the laboratory that includes:
   a. The specific reasons for the denial; and
   b. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
I. The Department shall issue:

1. A registry identification card, renewal of a dispensary registration certificate, an approval to operate a dispensary, renewal of a laboratory registration certificate, an approval for testing, or an approval to add a parameter, as applicable, if the Department determines that the applicant complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;

2. For an applicant for a registry identification card, a denial that includes the reason for the denial and the process for requesting judicial review if:
   a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 and this Chapter; or
   b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information;

3. For an applicant for an initial dispensary registration certificate, if the Department determines that the dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter:
   a. A dispensary registration certificate, if not all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; or
   b. Written notice that:
      i. The dispensary registration certificate application complies with A.R.S. Title 36, Chapter 28.1 and this Chapter;
      ii. The applicant was not allocated a dispensary registration certificate according to the criteria and processes in R9-17-303 because all available dispensary registration certificates have been allocated according to the criteria and processes in R9-17-303; and
      iii. The written notice is not a denial and is not considered a final decision of the Department subject to administrative review; or

4. For an applicant for a dispensary registration certificate, an approval to operate, a laboratory registration certificate, an approval for testing, or an approval to add a parameter, a denial that includes the reason for the denial and the process for administrative review if:
   a. The Department determines that the applicant does not comply with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
   b. The applicant does not submit all of the information and documents listed in the written comprehensive request or supplemental request for information within 10 working days after the date of the comprehensive written request or supplemental request for information.
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**R9-17-108.** Expiration of a Registry Identification Card, Dispensary Registration Certificate, or Laboratory Registration Certificate
A. Except as provided in subsection (B), a registry identification card issued to a qualifying patient, designated caregiver, dispensary agent, or laboratory agent is valid for two years after the date of issuance.

B. If the Department issues a registry identification card to a qualifying patient, designated caregiver, dispensary agent, or laboratory agent based on a request for a replacement registry identification card or an application to change or amend a registry identification card, the replacement, changed, or amended registry identification card shall have the same expiration date as the registry identification card being replaced, changed, or amended.

C. Except as provided in subsection (D), a dispensary registration certificate is valid for two years after the date of issuance.

D. If the Department issues an amended dispensary registration certificate based on a change of location or an addition of a cultivation site, the dispensary registration certificate shall have the same expiration date as the dispensary registration certificate previously held by the dispensary.

E. An approval to operate a dispensary shall have the same expiration date as the dispensary registration certificate associated with the approval to operate the dispensary.

F. A laboratory registration certificate is valid for two years after the original date of issuance.

G. A laboratory’s approval for testing shall have the same expiration date as the laboratory registration certificate associated with the laboratory’s approval to test.

R9-17-109. Notifications and Void Registry Identification Cards

A. The Department shall provide written notice that a cardholder’s registry identification card is void and no longer valid under A.R.S. Title 36, Chapter 28.1 and this Chapter to a:

1. Qualifying patient when the Department receives notification from:
   a. The qualifying patient that the qualifying patient no longer has a debilitating medical condition, or
   b. The physician who provided the qualifying patient’s written certification that the:
      i. Qualifying patient no longer has a debilitating medical condition,
      ii. Physician no longer believes that the qualifying patient would receive therapeutic or palliative benefit from the medical use of marijuana, or
      iii. Physician believes that the qualifying patient is not using the medical marijuana as recommended;

2. Designated caregiver when:
a. The Department receives notification from the designated caregiver’s qualifying patient that the designated caregiver no longer assists the qualifying patient with the medical use of marijuana, or
b. The registry identification card for the qualifying patient that is listed on the designated caregiver’s registry identification card is no longer valid;

3. Dispensary agent when:
   a. The Department receives the written notification, required in R9-17-310(A)(9), that the dispensary agent:
      i. No longer serves as a principal officer, board member, or medical director for the dispensary;
      ii. Is no longer employed by the dispensary; or
      iii. No longer provides volunteer service at or on behalf of the dispensary; or
   b. The registration certificate for the dispensary that is listed on the dispensary agent’s registry identification card is no longer valid; or

4. Laboratory agent when:
   a. The Department receives the written notification, required in R9-17-404(10), that the laboratory agent no longer:
      i. Serves as an owner for the laboratory,
      ii. Is employed by the laboratory, or
      iii. Provides volunteer service at or on behalf of the laboratory; or
   b. The registration certificate for the laboratory that is listed on the laboratory agent’s registration identification card is no longer valid.

B. The Department shall void a qualifying patient’s registry identification card:
   1. When the Department receives notification that the qualifying patient is deceased; or
   2. For a qualifying patient under 18 years of age, when the qualifying patient’s designated caregiver’s registry identification card is revoked.

C. The written notice required in subsection (A) that a registry identification card is void is not a revocation and is not considered a final decision of the Department subject to judicial review.
ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS

R9-17-201. Debilitating Medical Conditions
An individual applying for a qualifying patient registry identification card shall have a diagnosis from a physician of at least one of the following debilitating medical conditions:

1. Cancer;
2. Glaucoma;
3. Human immunodeficiency virus;
4. Acquired immune deficiency syndrome;
5. Hepatitis C;
6. Amyotrophic lateral sclerosis;
7. Crohn’s disease;
8. Agitation of Alzheimer’s disease;
9. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces cachexia or wasting syndrome;
10. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe and chronic pain;
11. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe nausea;
12. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces seizures, including those characteristic of epilepsy;
13. A chronic or debilitating disease or medical condition or the treatment for a chronic or debilitating disease or medical condition that produces severe or persistent muscle spasms, including those characteristic of multiple sclerosis; or
14. A debilitating medical condition approved by the Department under A.R.S. § 36-2801.01 and R9-17-106.

R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver
A. Except for a qualifying patient who is under 18 years of age, a qualifying patient is not required to have a designated caregiver.
B. A qualifying patient may have only one designated caregiver at any given time.
C. Except for a qualifying patient who is under 18 years of age, if the information submitted for a qualifying patient complies with A.R.S. Title 36, Chapter 28.1 and this Chapter but the information for the qualifying patient’s designated caregiver does not comply with A.R.S. Title 36, Chapter 28.1 and
this Chapter, the Department shall issue the registry identification card for the qualifying patient separate from issuing a registry identification card for the qualifying patient’s designated caregiver.

D. If the Department issues a registry identification card to a qualifying patient under subsection (C), the Department shall continue the process for issuing or denying the qualifying patient’s designated caregiver’s registry identification card.

E. The Department shall not issue a designated caregiver’s registry identification card before the Department issues the designated caregiver’s qualifying patient’s registry identification card.

F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s:
      i. First name; middle initial, if applicable; last name; and suffix, if applicable;
      ii. Date of birth; and
      iii. Gender;
   b. Except as provided in subsection (F)(1)(i), the qualifying patient’s residence address and mailing address;
   c. The county where the qualifying patient resides;
   d. The qualifying patient’s e-mail address;
   e. The identifying number on the applicable card or document in subsection (F)(2)(a) through (e);
   f. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;
   g. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
   h. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;
   i. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;
   j. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
   k. An attestation that the information provided in the application is true and correct; and
   l. The signature of the qualifying patient and date the qualifying patient signed;

2. A copy of the qualifying patient’s:
   a. Arizona driver’s license issued on or after October 1, 1996;
b. Arizona identification card issued on or after October 1, 1996;
c. Arizona registry identification card;
d. Photograph page in the qualifying patient’s U.S. passport; or
e. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the qualifying patient:
   i. Birth certificate verifying U.S. citizenship,
   ii. U.S. Certificate of Naturalization, or
   iii. U.S. Certificate of Citizenship;
3. A current photograph of the qualifying patient;
4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;
5. A physician’s written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s application that includes:
   a. The physician’s:
      i. Name,
      ii. License number including an identification of the physician license type,
      iii. Office address on file with the physician’s licensing board,
      iv. Telephone number on file with the physician’s licensing board, and
      v. E-mail address;
   b. The qualifying patient’s name and date of birth;
   c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
   d. An identification, initialed by the physician, of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;
   e. If the debilitating medical condition identified in subsection (F)(5)(d) is a condition in:
      i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
      ii. R9-17-201(14), the debilitating medical condition;
   f. A statement, initialed by the physician, that the physician:
      i. Has established a medical record for the qualifying patient, and
      ii. Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
   g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the
qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;
h. The date the physician conducted the in-person physical examination of the qualifying patient;
i. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   i. Medical records including medical records from other treating physicians from the previous 12 months,
   ii. Response to conventional medications and medical therapies, and
   iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
k. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;
l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:
   i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
   ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;
n. An attestation that the information provided in the written certification is true and correct; and

6. If the qualifying patient is designating a caregiver, the following in a Department-provided format:
a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;
b. The designated caregiver’s date of birth;
c. The designated caregiver’s residence address and mailing address;
d. The county where the designated caregiver resides;
e. The identifying number on the applicable card or document in subsection (F)(6)(i)(i) through (v);
f. One of the following:
   i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
   ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

g. An attestation signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

h. A statement signed by the designated caregiver:
   i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

i. A copy of the designated caregiver’s:
   i. Arizona driver’s license issued on or after October 1, 1996;
   ii. Arizona identification card issued on or after October 1, 1996;
   iii. Arizona registry identification card;
   iv. Photograph page in the designated caregiver’s U.S. passport; or
   v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:
      (1) Birth certificate verifying U.S. citizenship,
      (2) U.S. Certificate of Naturalization, or
      (3) U.S. Certificate of Citizenship;

j. A current photograph of the designated caregiver; and

k. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   i. The designated caregiver’s fingerprints on a fingerprint card that includes:
      (1) The designated caregiver’s first name; middle initial, if applicable; and last name;
      (2) The designated caregiver’s signature;
      (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
      (4) The designated caregiver’s address;
      (5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
      (6) The designated caregiver’s date of birth;
      (7) The designated caregiver’s Social Security number;
      (8) The designated caregiver’s citizenship status;
(9) The designated caregiver’s gender;
(10) The designated caregiver’s race;
(11) The designated caregiver’s height;
(12) The designated caregiver’s weight;
(13) The designated caregiver’s hair color;
(14) The designated caregiver’s eye color; and
(15) The designated caregiver’s place of birth; or

ii. If the designated caregiver’s fingerprints and information required in subsection 
(F)(6)(k)(i) were submitted to the Department as part of an application for a designated 
caregiver registry identification card, dispensary agent registry identification card, or 
laboratory agent registry identification card within the previous six months, the registry 
identification number on the registry identification card issued to the designated caregiver 
as a result of the application; and

7. The applicable fees in R9-17-102 for applying for:
   a. A qualifying patient registry identification card; and
   b. If applicable, a designated caregiver registry identification card.

G. To apply for a registry identification card for a qualifying patient who is under 18 years of age, the 
qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the 
qualifying patient shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s:
      i. First name; middle initial, if applicable; last name; and suffix, if applicable;
      ii. Date of birth; and
      iii. Gender;
   b. The qualifying patient’s residence address and mailing address;
   c. The county where the qualifying patient resides;
   d. The qualifying patient’s custodial parent’s or legal guardian’s first name; middle initial, if 
      applicable; last name; and suffix, if applicable;
   e. The identifying number on the applicable card or document in subsection (G)(5)(a) through 
      (e);
   f. The qualifying patient’s custodial parent’s or legal guardian’s residence address and mailing 
      address;
   g. The county where the qualifying patient’s custodial parent or legal guardian resides;
   h. The qualifying patient’s custodial parent’s or legal guardian’s e-mail address;
i. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;

j. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the patient’s medical record, maintained by other treating physicians, and is providing a written certification for medical marijuana for the qualifying patient;

k. The qualifying patient’s custodial parent’s or legal guardian’s date of birth;

l. Whether the qualifying patient’s custodial parent or legal guardian is requesting authorization for cultivating medical marijuana plants for the qualifying patient’s medical use because the qualifying patient’s custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;

m. Whether the qualifying patient’s custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;

n. Whether the individual submitting the application on behalf of the qualifying patient under 18 years of age is the qualifying patient’s custodial parent or legal guardian;

o. One of the following:
   i. A statement that the qualifying patient’s custodial parent or legal guardian does not currently hold a valid registry identification card, or
   ii. The assigned registry identification number for the qualifying patient’s custodial parent or legal guardian for each valid registry identification card currently held by the qualifying patient’s custodial parent or legal guardian;

p. An attestation that the information provided in the application is true and correct; and

q. The signature of the qualifying patient’s custodial parent or legal guardian and the date the qualifying patient’s custodial parent or legal guardian signed;

2. A current photograph of the:
   a. Qualifying patient, and
   b. Qualifying patient’s custodial parent or legal guardian serving as the qualifying patient’s designated caregiver;

3. An attestation in a Department-provided format signed and dated by the qualifying patient’s custodial parent or legal guardian that the qualifying patient’s custodial parent or legal guardian has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

4. A statement in a Department-provided format signed by the qualifying patient’s custodial parent or legal guardian who is serving as the qualifying patient’s designated caregiver:
   a. Allowing the qualifying patient’s medical use of marijuana;
b. Agreeing to assist the qualifying patient with the medical use of marijuana; and

c. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A copy of one of the following for the qualifying patient’s custodial parent or legal guardian:

a. Arizona driver’s license issued on or after October 1, 1996;

b. Arizona identification card issued on or after October 1, 1996;

c. Arizona registry identification card;

d. Photograph page in the qualifying patient’s custodial parent or legal guardian U.S. passport; or

e. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the qualifying patient’s custodial parent or legal guardian:

i. Birth certificate verifying U.S. citizenship,

ii. U.S. Certificate of Naturalization, or

iii. U.S. Certificate of Citizenship;

6. If the individual submitting the application on behalf of a qualifying patient is the qualifying patient’s legal guardian, a copy of documentation establishing the individual as the qualifying patient’s legal guardian;

7. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:

a. The qualifying patient’s custodial parent or legal guardian’s fingerprints on a fingerprint card that includes:

i. The qualifying patient’s custodial parent or legal guardian’s first name; middle initial, if applicable; and last name;

ii. The qualifying patient’s custodial parent or legal guardian’s signature;

iii. If different from the qualifying patient’s custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient’s custodial parent’s or legal guardian’s fingerprints;

iv. The qualifying patient’s custodial parent’s or legal guardian’s address;

v. If applicable, the qualifying patient’s custodial parent’s or legal guardian’s surname before marriage and any names previously used by the qualifying patient’s custodial parent or legal guardian;

vi. The qualifying patient’s custodial parent’s or legal guardian’s date of birth;

vii. The qualifying patient’s custodial parent’s or legal guardian’s Social Security number;

viii. The qualifying patient’s custodial parent’s or legal guardian’s citizenship status;

ix. The qualifying patient’s custodial parent’s or legal guardian’s gender;

x. The qualifying patient’s custodial parent’s or legal guardian’s race;
xi. The qualifying patient’s custodial parent’s or legal guardian’s height;

xii. The qualifying patient’s custodial parent’s or legal guardian’s weight;

xiii. The qualifying patient’s custodial parent’s or legal guardian’s hair color;

xiv. The qualifying patient’s custodial parent’s or legal guardian’s eye color; and

xv. The qualifying patient’s custodial parent’s or legal guardian’s place of birth; or

b. If the qualifying patient’s custodial parent’s or legal guardian’s fingerprints and information required in subsection (G)(7)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the qualifying patient’s custodial parent or legal guardian as a result of the application;

8. A written certification from the physician in subsection (G)(1)(i) and a separate written certification from the physician in (G)(1)(j) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s application that includes:

a. The physician’s:
   i. Name,
   ii. License number including an identification of the physician license type,
   iii. Office address on file with the physician’s licensing board,
   iv. Telephone number on file with the physician’s licensing board, and
   v. E-mail address;

b. The qualifying patient’s name and date of birth;

c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;

d. If the debilitating medical condition identified in subsection (G)(9)(c) is a condition in:
   i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
   ii. R9-17-201(14), the debilitating medical condition;

e. For the physician listed in subsection (G)(1)(i):
   i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
   ii. A statement, initialed by the physician, that the physician:
      (1) Has established a medical record for the qualifying patient, and
      (2) Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;

iv. The date the physician conducted the in-person physical examination of the qualifying patient;

v. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   1. Medical records, including medical records from other treating physicians from the previous 12 months,
   2. Response to conventional medications and medical therapies, and
   3. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient; and

vii. A statement, initialed by the physician, that the physician has provided information to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient, if the qualifying patient is female, that warns about:
   1. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
   2. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;

f. For the physician listed in subsection (G)(1)(j), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient’s medical records from other treating physicians;

g. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;

h. A statement, initialed by the physician, that, if the physician has referred the qualifying patient’s custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;

i. An attestation that the information provided in the written certification is true and correct; and
j. The physician’s signature and the date the physician signed; and

9. The applicable fees in R9-17-102 for applying for a:
   a. Qualifying patient registry identification card, and
   b. Designated caregiver registry identification card.

**H.** For purposes of this Article, “25 miles” includes the area contained within a circle that extends for 25 miles in all directions from a specific location.

**I.** For purposes of this Article, “residence address” when used in conjunction with a qualifying patient means:
1. The street address including town or city and zip code assigned by a local jurisdiction; or
2. For property that does not have a street address assigned by a local jurisdiction, the legal description of the property on the title documents recorded by the assessor of the county in which the property is located.

**R9-17-203. Amending a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card**

**A.** To add a designated caregiver or to request a change of a qualifying patient’s designated caregiver, the qualifying patient shall submit to the Department, within 10 working days after the addition or the change, the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s name and the registry identification number on the qualifying patient’s current registry identification card;
   b. If applicable, the name of the qualifying patient’s current designated caregiver and the date the designated caregiver last provided or will last provide assistance to the qualifying patient;
   c. The name of the individual the qualifying patient is designating as caregiver; and
   d. The signature of the qualifying patient and date the qualifying patient signed;

2. For the caregiver the qualifying patient is designating:
   a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The designated caregiver’s date of birth;
   c. The designated caregiver’s residence address and mailing address;
   d. The county where the designated caregiver resides;
   e. The identifying number on the applicable card or document in subsection (A)(2)(i)(i) through (v);
   f. One of the following:
i. A statement that the designated caregiver does not currently hold a valid registry identification card, or

ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

g. An attestation in a Department-provided format signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

h. A statement in a Department-provided format signed by the designated caregiver:

i. Agreeing to assist the qualifying patient with the medical use of marijuana; and

ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

i. A copy the designated caregiver’s:

i. Arizona driver’s license issued on or after October 1, 1996;

ii. Arizona identification card issued on or after October 1, 1996;

iii. Arizona registry identification card;

iv. Photograph page in the designated caregiver’s U.S. passport; or

v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:

   (1) Birth certificate verifying U.S. citizenship,
   (2) U.S. Certificate of Naturalization, or
   (3) U.S. Certificate of Citizenship;

j. A current photograph of the designated caregiver; and

k. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:

i. The designated caregiver’s fingerprints on a fingerprint card that includes:

   (1) The designated caregiver’s first name; middle initial, if applicable; and last name;
   (2) The designated caregiver’s signature;
   (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
   (4) The designated caregiver’s address;
   (5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
   (6) The designated caregiver’s date of birth;
   (7) The designated caregiver’s Social Security number;
   (8) The designated caregiver’s citizenship status;
(9) The designated caregiver’s gender;
(10) The designated caregiver’s race;
(11) The designated caregiver’s height;
(12) The designated caregiver’s weight;
(13) The designated caregiver’s hair color;
(14) The designated caregiver’s eye color; and
(15) The designated caregiver’s place of birth; or

ii. If the designated caregiver’s fingerprints and information required in subsection (A)(2)(k)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and

3. The applicable fee in R9-17-102 for applying for a designated caregiver registry identification card.

B. To amend a qualifying patient’s address on the qualifying patient’s registry identification card when the qualifying patient or the qualifying patient’s designated caregiver is authorized to cultivate marijuana, the qualifying patient shall submit to the Department, within 10 working days after the change in address, the following:

1. The qualifying patient’s name and the registry identification number on the qualifying patient’s current registry identification card;
2. The qualifying patient’s new address;
3. The county where the new address is located;
4. The name of the qualifying patient’s designated caregiver, if applicable;
5. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
6. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;
7. The effective date of the qualifying patient’s new address; and
8. The applicable fee in R9-17-102 for applying to:
   a. Amend a qualifying patient’s registry identification card; and
   b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver’s registry identification card.
C. To request authorization to cultivate marijuana based on a qualifying patient’s current address or a new address, the qualifying patient shall submit to the Department, if applicable within 10 working days after the change in address, the following:

1. The qualifying patient’s name and the registry identification number on the qualifying patient’s current registry identification card;
2. If the qualifying patient’s address is a new address, the qualifying patient’s:
   a. Current address,
   b. New address,
   c. The county where the new address is located, and
   d. The effective date of the qualifying patient’s new address;
3. The name of the qualifying patient’s designated caregiver, if applicable;
4. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
5. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use; and
6. The applicable fee in R9-17-102 for applying to:
   a. Amend a qualifying patient’s registry identification card; and
   b. If the qualifying patient is designating a designated caregiver for cultivation authorization, amend a designated caregiver’s registry identification card.

R9-17-204. Renewing a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card

A. Except for a qualifying patient who is under 18 years of age, to renew a qualifying patient’s registry identification card, the qualifying patient shall submit the following to the Department at least 30 calendar days before the expiration date of the qualifying patient’s registry identification card:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The qualifying patient’s date of birth;
   c. Except as provided in subsection (A)(1)(j), the qualifying patient’s residence address and mailing address;
   d. The county where the qualifying patient resides;
e. The qualifying patient’s e-mail address;
f. The registry identification number on the qualifying patient’s current registry identification card;
g. The name, address, and telephone number of the physician providing the written certification for medical marijuana for the qualifying patient;
h. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;
i. If the qualifying patient is requesting authorization for cultivating marijuana plants, whether the qualifying patient is designating the qualifying patient’s designated caregiver to cultivate marijuana plants for the qualifying patient’s medical use;
j. If the qualifying patient is homeless, an address where the qualifying patient can receive mail;
k. Whether the qualifying patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;
l. An attestation that the information provided in the application is true and correct; and
m. The signature of the qualifying patient and the date the qualifying patient signed;

2. If the qualifying patient’s name in subsection (A)(1)(a) is not the same name as on the qualifying patient’s current registry identification card, one of the following with the qualifying patient’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the qualifying patient’s U.S. passport;

3. A current photograph of the qualifying patient;

4. A statement in a Department-provided format signed by the qualifying patient pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A physician’s written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s renewal application that includes:
   a. The physician’s:
      i. Name,
      ii. License number including an identification of the physician license type,
      iii. Office address on file with the physician’s licensing board,
      iv. Telephone number on file with the physician’s licensing board, and
      v. E-mail address;
b. The qualifying patient’s name and date of birth;
c. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
d. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;
e. If the debilitating medical condition identified in subsection (A)(5)(d) is a condition in:
   i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
   ii. R9-17-201(14), the debilitating medical condition;
f. A statement, initialed by the physician, that the physician:
   i. Has established a medical record for the qualifying patient, and
   ii. Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
g. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;
h. The date the physician conducted the in-person physical examination of the qualifying patient;
i. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
   i. Medical records including medical records from other treating physicians from the previous 12 months,
   ii. Response to conventional medications and medical therapies, and
   iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
j. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient;
k. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;
l. A statement, initialed by the physician, that, if the physician has referred the qualifying patient to a dispensary, the physician has disclosed to the qualifying patient any personal or professional relationship the physician has with the dispensary;
m. A statement, initialed by the physician, that the physician has provided information to the qualifying patient, if the qualifying patient is female, that warns about:
i. The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and

ii. The risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;

n. An attestation that the information provided in the written certification is true and correct; and

o. The physician’s signature and the date the physician signed;

6. If the qualifying patient is designating a caregiver or if the qualifying patient’s designated caregiver’s registry identification card has the same expiration date as the qualifying patient’s registry identification card, the following in a Department-provided format:

a. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;

b. The designated caregiver’s date of birth;

c. The designated caregiver’s residence address and mailing address;

d. The county where the designated caregiver resides;

e. If the qualifying patient is renewing the designated caregiver’s registry identification card, the registry identification number on the designated caregiver’s registry identification card associated with the qualifying patient;

f. If the qualifying patient is designating an individual not previously designated as the qualifying patient’s designated caregiver, the identification number on and a copy of the designated caregiver’s:

   i. Arizona driver’s license issued on or after October 1, 1996;

   ii. Arizona identification card issued on or after October 1, 1996;

   iii. Arizona registry identification card;

   iv. Photograph page in the designated caregiver’s U.S. passport; or

   v. Arizona driver’s license or identification card issued before October 1, 1996 and one of the following for the designated caregiver:

      (1) Birth certificate verifying U.S. citizenship,

      (2) U.S. Certificate of Naturalization, or

      (3) U.S. Certificate of Citizenship;

   g. If the qualifying patient is designating an individual not previously designated as the qualifying patient’s designated caregiver, one of the following:

      i. A statement that the designated caregiver does not currently hold a valid registry identification card, or
ii. The assigned registry identification number for the designated caregiver for each valid registry identification card currently held by the designated caregiver;

h. A current photograph of the designated caregiver;

i. An attestation signed and dated by the designated caregiver that the designated caregiver has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

j. A statement in a Department-provided format signed by the designated caregiver:
   i. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   ii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and

k. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   i. The designated caregiver’s fingerprints on a fingerprint card that includes:
      (1) The designated caregiver’s first name; middle initial, if applicable; and last name;
      (2) The designated caregiver’s signature;
      (3) If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
      (4) The designated caregiver’s address;
      (5) If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
      (6) The designated caregiver’s date of birth;
      (7) The designated caregiver’s Social Security number;
      (8) The designated caregiver’s citizenship status;
      (9) The designated caregiver’s gender;
      (10) The designated caregiver’s race;
      (11) The designated caregiver’s height;
      (12) The designated caregiver’s weight;
      (13) The designated caregiver’s hair color;
      (14) The designated caregiver’s eye color; and
      (15) The designated caregiver’s place of birth; or
   ii. If the designated caregiver’s fingerprints and information required in subsection (A)(6)(k)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application;
7. If the qualifying patient’s designated caregiver’s registry identification card has the same expiration date as the qualifying patient’s registry identification card and the designated caregiver’s name in subsection (A)(6)(a) is not the same name as on the designated caregiver’s current registry identification card, one of the following with the designated caregiver’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the designated caregiver’s U.S. passport; and
8. The applicable fees in R9-17-102 for applying to:
   a. Renew a qualifying patient’s registry identification card; and
   b. If applicable, issue or renew a designated caregiver’s registry identification card.

B. To renew a registry identification card for a qualifying patient who is under 18 years of age, the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient shall submit to the Department the following:
1. An application in a Department-provided format that includes:
   a. The qualifying patient’s:
      i. First name; middle initial, if applicable; last name; and suffix, if applicable; and
      ii. Date of birth;
   b. The qualifying patient’s residence address and mailing address;
   c. The county where the qualifying patient resides;
   d. The registry identification number on the qualifying patient’s current registry identification card;
   e. The qualifying patient’s custodial parent’s or legal guardian’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   f. The qualifying patient’s custodial parent’s or legal guardian’s residence address and mailing address;
   g. The county where the qualifying patient’s custodial parent or legal guardian resides;
   h. The qualifying patient’s custodial parent’s or legal guardian’s e-mail address;
   i. The registry identification number on the qualifying patient’s custodial parent’s or legal guardian’s current registry identification card;
   j. The name, address, and telephone number of a physician who has a physician-patient relationship with the qualifying patient and is providing the written certification for medical marijuana for the qualifying patient;
   k. The name, address, and telephone number of a second physician who has conducted a comprehensive review of the qualifying patient’s medical record maintained by other treating
physicians, and is providing a written certification for medical marijuana for the qualifying patient;

1. Whether the qualifying patient’s custodial parent or legal guardian is requesting approval for cultivating marijuana plants for the qualifying patient’s medical use because the qualifying patient’s custodial parent or legal guardian believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;

m. Whether the qualifying patient’s custodial parent or legal guardian would like notification of any clinical studies needing human subjects for research on the medical use of marijuana;

n. A statement in a Department-provided format signed by the qualifying patient’s custodial parent or legal guardian who is serving as the qualifying patient’s designated caregiver:
   i. Allowing the qualifying patient’s medical use of marijuana;
   ii. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   iii. Pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

o. An attestation that the information provided in the application is true and correct; and

p. The signature of the qualifying patient’s custodial parent or legal guardian and the date the qualifying patient’s custodial parent or legal guardian signed;

2. If the qualifying patient’s custodial parent’s or legal guardian’s name in subsection (B)(1)(e) is not the same name as on the qualifying patient’s custodial parent’s or legal guardian’s current registry identification card, one of the following with the custodial parent’s or legal guardian’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the qualifying patient’s custodial parent’s or legal guardian’s U.S. passport;

3. A current photograph of the qualifying patient;

4. A written certification from the physician in subsection (B)(1)(j) and a separate written certification from the physician in subsection (B)(1)(k) in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient’s renewal application that includes:
   a. The physician’s:
      i. Name,
      ii. License number including an identification of the physician license type,
      iii. Office address on file with the physician’s licensing board,
      iv. Telephone number on file with the physician’s licensing board, and
      v. E-mail address;
b. The qualifying patient’s name and date of birth;
c. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient’s specific debilitating medical condition;
d. If the debilitating medical condition identified in subsection (B)(4)(c) is a condition in:
   i. R9-17-201(9) through (13), the underlying chronic or debilitating disease or medical condition; or
   ii. R9-17-201(14), the debilitating medical condition;
e. For the physician listed in subsection (B)(1)(j):
   i. A statement that the physician has made or confirmed a diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient;
   ii. A statement, initialed by the physician, that the physician:
      (1) Has established a medical record for the qualifying patient, and
      (2) Is maintaining the qualifying patient’s medical record as required in A.R.S. § 12-2297;
   iii. A statement, initialed by the physician, that the physician has conducted an in-person physical examination of the qualifying patient within the previous 90 calendar days appropriate to the qualifying patient’s presenting symptoms and the qualifying patient’s debilitating medical condition diagnosed or confirmed by the physician;
   iv. The date the physician conducted the in-person physical examination of the qualifying patient;
   v. A statement, initialed by the physician, that the physician reviewed the qualifying patient’s:
      (1) Medical records including medical records from other treating physicians from the previous 12 months,
      (2) Response to conventional medications and medical therapies, and
      (3) Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;
   vi. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of medical marijuana to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient; and
   vii. A statement, initialed by the physician, that the physician has provided information to the qualifying patient’s custodial parent or legal guardian responsible for health care decisions for the qualifying patient, if the qualifying patient is female, that warns about:
      (1) The potential dangers to a fetus caused by smoking or ingesting marijuana while pregnant or to an infant while breastfeeding, and
      (2) The risk of being reported to the Department of Child Safety during pregnancy or at
the birth of the child by persons who are required to report;

f. For the physician listed in subsection (B)(1)(k), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient’s medical records from other treating physicians;

g. A statement, initialed by the physician, that, in the physician’s professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient’s medical use of marijuana to treat or alleviate the qualifying patient’s debilitating medical condition;

h. A statement, initialed by the physician, that, if the physician has referred the qualifying patient’s custodial parent or legal guardian to a dispensary, the physician has disclosed to the qualifying patient’s custodial parent or legal guardian any personal or professional relationship the physician has with the dispensary;

i. An attestation that the information provided in the written certification is true and correct; and

j. The physician’s signature and the date the physician signed; and

5. A current photograph of the qualifying patient’s custodial parent or legal guardian;

6. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:

a. The qualifying patient’s custodial parent’s or legal guardian’s fingerprints on a fingerprint card that includes:

i. The qualifying patient’s custodial parent’s or legal guardian’s first name; middle initial, if applicable; and last name;

ii. The qualifying patient’s custodial parent’s or legal guardian’s signature;

iii. If different from the qualifying patient’s custodial parent or legal guardian, the signature of the individual physically rolling the qualifying patient’s custodial parent’s or legal guardian’s fingerprints;

iv. The qualifying patient’s custodial parent’s or legal guardian’s address;

v. If applicable, the qualifying patient’s custodial parent’s or legal guardian’s surname before marriage and any names previously used by the qualifying patient’s custodial parent or legal guardian;

vi. The qualifying patient’s custodial parent’s or legal guardian’s date of birth;

vii. The qualifying patient’s custodial parent’s or legal guardian’s Social Security number;

viii. The qualifying patient’s custodial parent’s or legal guardian’s citizenship status;

ix. The qualifying patient’s custodial parent’s or legal guardian’s gender;

x. The qualifying patient’s custodial parent’s or legal guardian’s race;

xi. The qualifying patient’s custodial parent’s or legal guardian’s height;
xii. The qualifying patient’s custodial parent’s or legal guardian’s weight;
xiii. The qualifying patient’s custodial parent’s or legal guardian’s hair color;
xiv. The qualifying patient’s custodial parent’s or legal guardian’s eye color; and
xv. The qualifying patient’s custodial parent’s or legal guardian’s place of birth; or

b. If the qualifying patient’s custodial parent’s or legal guardian’s fingerprints and information required in subsection (B)(6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the patient’s custodial parent or legal guardian serving as the qualifying patient’s designated caregiver as a result of the application; and

7. The applicable fees in R9-17-102 for applying to renew a:
   a. Qualifying patient’s registry identification card, and
   b. Designated caregiver’s registry identification card.

C. Except as provided in subsection (A)(6), to renew a qualifying patient’s designated caregiver’s registry identification card, the qualifying patient shall submit to the Department, at least 30 calendar days before the expiration date of the designated caregiver’s registry identification card, the following:

1. An application in a Department-provided format that includes:
   a. The qualifying patient’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The registry identification number on the qualifying patient’s current registry identification card;
   c. The designated caregiver’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   d. The designated caregiver’s date of birth;
   e. The designated caregiver’s residence address and mailing address;
   f. The county where the designated caregiver resides;
   g. The registry identification number on the designated caregiver’s current registry identification card;

2. If the designated caregiver’s name in subsection (C)(1)(a) is not the same name as on the designated caregiver’s current registry identification card, one of the following with the designated caregiver’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
c. The photograph page in the designated caregiver’s U.S. passport;

3. A current photograph of the designated caregiver;

4. A statement in a Department-provided format signed by the designated caregiver:
   a. Agreeing to assist the qualifying patient with the medical use of marijuana; and
   b. Pledging not to divert marijuana to any individual or person who is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1; and

5. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   a. The designated caregiver’s fingerprints on a fingerprint card that includes:
      i. The designated caregiver’s first name; middle initial, if applicable; and last name;
      ii. The designated caregiver’s signature;
      iii. If different from the designated caregiver, the signature of the individual physically rolling the designated caregiver’s fingerprints;
      iv. The designated caregiver’s address;
      v. If applicable, the designated caregiver’s surname before marriage and any names previously used by the designated caregiver;
      vi. The designated caregiver’s date of birth;
      vii. The designated caregiver’s Social Security number;
      viii. The designated caregiver’s citizenship status;
      ix. The designated caregiver’s gender;
      x. The designated caregiver’s race;
      xi. The designated caregiver’s height;
      xii. The designated caregiver’s weight;
      xiii. The designated caregiver’s hair color;
      xiv. The designated caregiver’s eye color; and
      xv. The designated caregiver’s place of birth; or
   b. If the designated caregiver’s fingerprints and information required in subsection (C)(1)(j)(i) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the designated caregiver as a result of the application; and

6. The applicable fee in R9-17-102 for renewing a designated caregiver’s registry identification card.

R9-17-205. Denial or Revocation of a Qualifying Patient’s or Designated Caregiver’s Registry Identification Card
A. The Department shall deny a qualifying patient’s application for or renewal of the qualifying patient’s registry identification card if the qualifying patient does not have a debilitating medical condition.

B. The Department shall deny a designated caregiver’s application for or renewal of the designated caregiver’s registry identification card if the designated caregiver does not meet the definition of “designated caregiver” in A.R.S. § 36-2801.

C. The Department may deny a qualifying patient’s or designated caregiver’s application for or renewal of the qualifying patient’s or designated caregiver’s registry identification card if the qualifying patient or designated caregiver:
   1. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter; or
   2. Provides false or misleading information to the Department.

D. The Department shall revoke a qualifying patient’s or designated caregiver’s registry identification card if the qualifying patient or designated caregiver diverts medical marijuana to an individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1.

E. The Department shall revoke a designated caregiver’s registry identification card if the designated caregiver has been convicted of an excluded felony offense.

F. The Department may revoke a qualifying patient’s or designated caregiver’s registry identification card if the qualifying patient or designated caregiver knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.

G. If the Department denies or revokes a qualifying patient’s registry identification card, the Department shall provide written notice to the qualifying patient that includes:
   1. The specific reason or reasons for the denial or revocation; and
   2. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

H. If the Department denies or revokes a qualifying patient’s designated caregiver’s registry identification card, the Department shall provide written notice to the qualifying patient and the designated caregiver that includes:
   1. The specific reason or reasons for the denial or revocation; and
   2. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.
ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS

R9-17-301. Principal Officers and Board Members

A. For the purposes of this Chapter, in addition to the individual or individuals identified in the dispensary’s by-laws or other organizational governing documents as principal officers of the dispensary, if applicable, the following individuals are considered principal officers:

1. If a corporation is applying for a dispensary registration certificate, two individuals who are officers of the corporation, including, but not limited to, the president or chief executive officer and those individuals serving in the positions of secretary and treasurer;

2. If a partnership is applying for a dispensary registration certificate, all individuals who are general partners and the principal officers of any entity general partner;

3. If a limited liability company is applying for a dispensary registration certificate, all managers of a manager-managed limited liability company, all members of a member-managed limited liability company, and the principal officers of an entity manager or member;

4. If an association or cooperative is applying for a dispensary registration certificate, the chief executive officer, executive director, or other comparable leader of the association or cooperative; and

5. If a business organization type other than those described in subsections (A)(1) through (4) is applying for a dispensary registration certificate, two individuals who occupy the top leadership positions of the business organization.

B. For purposes of this Chapter, in addition to the individual or individuals identified in the dispensary’s by-laws or other organizational governing documents as board members of the dispensary, if applicable, the following individuals are considered board members:

1. If a corporation is applying for a dispensary registration certificate, the members of the board of directors of the corporation;

2. If a partnership is applying for a dispensary registration certificate, the partners who are not limited partners;

3. If a limited liability company is applying for a dispensary registration certificate, the principal officers of the limited liability company;

4. If an association or cooperative is applying for a dispensary registration certificate, the principal officers of the association or cooperative; and

5. If a business organization type other than the types of business organizations in subsections (B)(1) through (4), the principal officers of the business organization.

R9-17-302. Repealed
R9-17-303. Dispensary Registration Certificate Allocation Process

A. Each calendar year, the Department may review current valid dispensary registration certificates to determine if the Department may issue additional dispensary registration certificates pursuant to A.R.S. § 36-2804(C).

1. If the Department determines that the Department may issue additional dispensary registration certificates, the Department shall post, on the Department’s website, the information that the Department is accepting dispensary registration certificate applications, including the deadline for accepting dispensary registration certificate applications.
   a. The Department shall post the information in subsection (A)(1) at least 30 calendar days before the date the Department begins accepting applications.
   b. The deadline for submission of dispensary registration certificate applications is 10 working days after the date the Department begins accepting applications.
   c. Sixty working days after the date the Department begins accepting applications, the Department shall determine if the Department received more dispensary registration certificate applications that are complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the Department is allowed to issue.
      i. If the Department received more dispensary registration certificate applications than the Department is allowed to issue, the Department shall allocate any available dispensary registration certificates according to the priorities established in subsection (B).
      ii. If the Department is allowed to issue a dispensary registration certificate for each dispensary registration certificate application the Department received, the Department shall allocate the dispensary registration certificates to those applicants.

2. If the Department determines that the Department is not allowed to issue additional dispensary registration certificates, the Department shall, on the Department’s website:
   a. Post the information that the Department is not accepting dispensary registration certificate applications, and
   b. Maintain the information until the next review.

B. If the Department receives, by 60 working days after the date the Department begins accepting applications, more dispensary registration certificate applications that are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process than the Department is allowed to issue, the Department shall allocate the dispensary registration certificates according to the following criteria:
1. If dispensary registration certificate applications are received for a county that does not contain a dispensary:
   a. If only one dispensary registration certificate application is received for a dispensary located in the county, the Department shall allocate the dispensary registration certificate to that applicant; or
   b. If more than one dispensary registration certificate application is received for a dispensary located in the county, the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to subsection (B)(2);

2. For dispensary registration certificate applications received according to subsection (B)(1)(b), the Department shall prioritize and allocate a dispensary registration certificate to an applicant according to the following:
   a. If only one dispensary registration certificate application is received for a dispensary located in a geographic area in the county that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall allocate the dispensary registration certificate to that applicant;
   b. If more than one dispensary registration certificate application is received for a dispensary located in a geographic area in the county that is at least 25 miles from another dispensary and from which another dispensary has moved, the Department shall prioritize and allocate a dispensary registration certificate to an applicant based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary location, as determined from the number of registry identification cards issued to qualifying patients; and
   c. If no dispensary registration certificate applications are received for a dispensary located in a geographic area in the county that meets the criteria in subsection (2)(a), the Department shall allocate a dispensary registration certificate in the county as follows:
      i. If only one dispensary registration certificate application is received for a dispensary located in a geographic area that is at least 25 miles from another dispensary, the Department shall allocate the dispensary registration certificate to that applicant;
      ii. If more than one dispensary registration certificate application is received for a dispensary located in a geographic area that is at least 25 miles from another dispensary, the Department shall allocate a dispensary registration certificate to an applicant based on random drawing; and
iii. If no dispensary registration certificate is allocated according to subsection (B)(2)(c)(i) or (ii), the Department shall allocate a dispensary registration certificate to an applicant for a dispensary located in the county based on random drawing;

3. If additional dispensary registration certificates are available after dispensary registration certificates are allocated for a county that does not contain a dispensary according to subsection (B)(1) or (2), the Department shall allocate the dispensary registration certificates as follows:
   a. If only one dispensary registration certificate application is received for a dispensary located in a geographic area that is at least 25 miles from another dispensary and from which another dispensary has moved since the previous allocation of dispensary registration certificates, the Department shall allocate the dispensary registration certificate to that applicant; or
   b. If more than one dispensary registration certificate application is received for a dispensary located in a geographic area that is at least 25 miles from another dispensary and from which another dispensary has moved since the previous allocation of dispensary registration certificates, the Department shall prioritize and allocate dispensary registration certificates to applicants based on which proposed dispensary location will provide dispensary services to the most qualifying patients within five miles of the proposed dispensary location, as determined from the number of registry identification cards issued to qualifying patients;

4. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1), (2), and (3), the Department shall allocate the dispensary registration certificates as follows:
   a. If only one dispensary registration certificate application is received for a dispensary located in a geographic area in which there are no other dispensaries operating within 25 miles of the geographic area, the Department shall allocate a dispensary registration certificate to that applicant; or
   b. If more than one dispensary registration certificate application is received for a dispensary located in a geographic area in which there are no other dispensaries operating within 25 miles of the geographic area, the Department shall allocate a dispensary registration certificate to an applicant based on random drawing; and

5. If additional dispensary registration certificates are available after dispensary registration certificates are allocated according to subsections (B)(1) through (4), for all dispensary registration certificate applications not allocated a dispensary registration certificate, the Department shall allocate a dispensary registration certificate to an applicant based on random drawing.
C. If there is a tie or a margin of 0.1% or less in the scores generated by applying the criteria in subsection (B), the Department shall randomly select one dispensary registration certificate application and allocate a dispensary registration certificate to that applicant.

D. For purposes of subsection (B):
   1. “Five miles” includes the area contained within a circle that extends for five miles in all directions from a specific location, not the distance traveled from the specific location by road; and
   2. “25 miles” includes the area contained within a circle that extends for 25 miles in all directions from the center of a geographic area, not the distance traveled from the center of the geographic area by road.

E. If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter to participate in the allocation process, the Department shall:
   1. Provide a written notice to the applicant that states that, although the applicant’s dispensary registration certificate application was complete and complied with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department did not allocate the applicant a dispensary registration certificate under the processes in this Section; and
   2. Return $1,000 of the application fee to the applicant.

F. If the Department receives a dispensary registration certificate application at a time other than the time stated in subsection (B), the Department shall return the dispensary registration certificate application, including the application fee, to the applicant.

R9-17-304. Applying for a Dispensary Registration Certificate

A. An individual shall not be an applicant, principal officer, or board member on:
   1. More than one dispensary registration certificate application for a location in a single geographic area, or
   2. More than five dispensary registration certificate applications for locations in different geographic areas.

B. If the Department determines that an individual is an applicant, principal officer, or board member on more than one dispensary registration certificate application for a geographic area or more than five dispensary registration certificate applications, the Department shall review the applications and provide the applicant on each of the dispensary registration certificate applications with a written comprehensive request for more information that includes the specific requirements in A.R.S. Title 36,
Chapter 28.1 and this Chapter that the dispensary registration certificate application does not comply with.

1. If an applicant withdraws an application to comply with this Chapter and submits information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall process the applicant’s remaining dispensary registration certificate applications according to this Chapter.

2. If an applicant does not withdraw an application or submit information demonstrating compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue a denial to the applicant according to R9-17-322.

3. An application fee submitted with a dispensary registration certificate application in subsection (B) that is withdrawn is not refunded.

C. To apply for a dispensary registration certificate, an applicant shall submit to the Department the following:

1. An application in a Department-provided format that includes:
   a. The legal name of the proposed dispensary;
   b. The physical address and geographic area of the proposed dispensary;
   c. The following information for the applicant:
      i. Name of the individual or entity applying,
      ii. Type of business organization,
      iii. Mailing address,
      iv. Telephone number, and
      v. E-mail address;
   d. The name of the individual designated to submit dispensary agent registry identification card applications on behalf of the proposed dispensary;
   e. The name and professional license number of the proposed dispensary’s medical director;
   f. The name, residence address, and date of birth of each:
      i. Principal officer, and
      ii. Board member;
   g. For each principal officer or board member, whether the principal officer or board member:
      i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked;
      ii. Is a physician currently providing written certifications for qualifying patients;
      iii. Is a law enforcement officer; or
      iv. Is employed by or a contractor of the Department;
h. Whether the applicant agrees to allow the Department to submit supplemental requests for information;
i. A statement that, if the applicant is issued a dispensary registration certificate, the proposed dispensary will not operate until the proposed dispensary is inspected and obtains an approval to operate from the Department;
j. An attestation that the information provided to the Department to apply for a dispensary registration certificate is true and correct; and
k. The signatures of each principal officer and each board member of the proposed dispensary according to R9-17-301 and the date signed;

2. If the applicant is one of the business organizations in R9-17-301(A)(2) through (7), a copy of the business organization’s articles of incorporation, articles of organization, or partnership or joint venture documents that include:
a. The name of the business organization,
b. The type of business organization, and
c. The names and titles of the individuals in R9-17-301(A) and (B);

3. For each principal officer and each board member:
a. An attestation signed and dated by the principal officer or board member that the principal officer or board member has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801; and
b. For the Department’s criminal records check authorized in A.R.S. §§ 36-2804 and 36-2804.05:
i. The principal officer’s or board member’s fingerprints on a fingerprint card that includes:
   (1) The principal officer’s or board member’s first name; middle initial, if applicable; and last name;
   (2) The principal officer’s or board member’s signature;
   (3) If different from the principal officer or board member, the signature of the individual physically rolling the principal officer’s or board member’s fingerprints;
   (4) The principal officer’s or board member’s residence address;
   (5) If applicable, the principal officer’s or board member’s surname before marriage and any names previously used by the principal officer or board member;
   (6) The principal officer’s or board member’s date of birth;
   (7) The principal officer’s or board member’s Social Security number;
   (8) The principal officer’s or board member’s citizenship status;
   (9) The principal officer’s or board member’s gender;
   (10) The principal officer’s or board member’s race;
(11) The principal officer’s or board member’s height;
(12) The principal officer’s or board member’s weight;
(13) The principal officer’s or board member’s hair color;
(14) The principal officer’s or board member’s eye color; and
(15) The principal officer’s or board member’s place of birth; or

ii. If the fingerprints and information required in subsection (C)(3)(b)(i) were submitted to
the Department as part of an application for a designated caregiver registry identification
card, dispensary agent registry identification card, or laboratory agent registry
identification card within the previous six months, the registry identification number on the
registry identification card issued to the principal officer or board member as a result of
the application;

4. Policies and procedures that comply with the requirements in this Chapter for:
   a. Inventory control,
   b. Laboratory testing of medical marijuana and medical marijuana products,
   c. Qualifying patient recordkeeping,
   d. Security, and
   e. Patient education and support;

5. As required in A.R.S. § 36-2804(B)(1)(d), a sworn statement, signed and dated by the each
principal officer and each board member of the proposed dispensary according to R9-17-301,
certifying that the proposed dispensary is in compliance with any local zoning restrictions;

6. Documentation from the local jurisdiction where the proposed dispensary’s physical address is
located that:
   a. There are no local zoning restrictions for the proposed dispensary’s location, or
   b. The proposed dispensary’s location is in compliance with any local zoning restrictions;

7. Documentation of:
   a. Ownership of the physical address of the proposed dispensary, or
   b. Permission from the owner of the physical address of the proposed dispensary for the applicant
      for a dispensary registration certificate to operate a dispensary at the physical address;

8. The proposed dispensary’s by-laws including:
   a. The names and titles of individuals designated as principal officers and board members of the
      proposed dispensary;
   b. Whether the applicant plans to:
      i. Cultivate marijuana;
      ii. Acquire marijuana from qualifying patients, designated caregivers, or other dispensaries;
iii. Sell or provide marijuana to other dispensaries;
iv. Transport marijuana;
v. Prepare, sell, or dispense marijuana-infused edible food products;
vi. Prepare, sell, or dispense marijuana-infused non-edible products;
vii. Sell or provide marijuana paraphernalia or other supplies related to the administration of marijuana to qualifying patients and designated caregivers;
viii. Deliver medical marijuana to qualifying patients; or
ix. Provide patient support and related services to qualifying patients;
c. Provisions for the disposition of revenues and receipts to ensure that the proposed dispensary operates on a not-for-profit basis; and
d. Provisions for amending the proposed dispensary’s by-laws;

9. A business plan demonstrating the on-going viability of the proposed dispensary on a not-for-profit basis that includes:
   a. A description and total dollar amount of expenditures already incurred to establish the proposed dispensary or to secure a dispensary registration certificate by the applicant for the dispensary registration certificate;
   b. A description and total dollar amount of monies or tangible assets received for operating the proposed dispensary from entities other than the applicant for the dispensary registration certificate or a principal officer or board member associated with the applicant, including the entity’s name and the interest in the dispensary or the benefit the entity obtained;
   c. Projected expenditures expected before the proposed dispensary is operational;
   d. Projected expenditures after the proposed dispensary is operational; and
   e. Projected revenue; and

10. The applicable fee in R9-17-102 for applying for a dispensary registration certificate.

D. Before an entity with a dispensary registration certificate begins operating a dispensary, the entity shall apply for and obtain an approval to operate a dispensary from the Department.

R9-17-305. Applying for Approval to Operate a Dispensary

A. To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit to the Department, and, if the dispensary registration certificate was issued on or after April 1, 2020, within 18 months after the dispensary registration certificate was issued, the following:

1. An application in a Department-provided format that includes:
   a. The name and registry identification number of the dispensary;
   b. The physical address of the dispensary;
c. The name, address, and date of birth of each dispensary agent;
d. Except as provided in R9-17-324, the name and professional license number of the dispensary’s medical director;
e. If applicable, the physical address of the dispensary’s cultivation site;
f. The dispensary’s Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
g. The dispensary’s proposed hours of operation during which the dispensary plans to be available to dispense medical marijuana to qualifying patients and designated caregivers;
h. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
i. Whether the dispensary and, if applicable, the dispensary’s cultivation site are ready for an inspection by the Department;
j. If the dispensary and, if applicable, the dispensary’s cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary’s cultivation site will be ready for an inspection by the Department;
k. An attestation that the information provided to the Department to apply for approval to operate a dispensary is true and correct; and
l. The signatures of each principal officer and each board member of the dispensary according to R9-17-301 and the date signed;

2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary’s cultivation site, such as a certificate of occupancy, a special use permit, or a conditional use permit;

3. A sworn statement, signed and dated by each principal officer and each board member of the dispensary according to R9-17-301, certifying that the dispensary is in compliance with local zoning restrictions;

4. The distance to the closest private school or public school from:
   a. The dispensary; and
   b. If applicable, the dispensary’s cultivation site;

5. A site plan drawn to scale of the dispensary location showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains;

6. A floor plan drawn to scale of the building where the dispensary is located showing the:
   a. Layout and dimensions of each room,
   b. Name and function of each room,
c. Location of each hand washing sink,
d. Location of each toilet room,
e. Means of egress,
f. Location of each video camera,
g. Location of each panic button, and
h. Location of natural and artificial lighting sources;

7. If applicable, a site plan drawn to scale of the dispensary’s cultivation site showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and

8. If applicable, a floor plan drawn to scale of each building at the dispensary’s cultivation site showing the:
   a. Layout and dimensions of each room,
   b. Name and function of each room,
   c. Location of each hand washing sink,
   d. Location of each toilet room,
   e. Means of egress,
   f. Location of each video camera,
   g. Location of each panic button, and
   h. Location of natural and artificial lighting sources.

B. A dispensary’s cultivation site may be located anywhere in the state where a cultivation site is allowed by the local jurisdiction.

R9-17-306. Changes to a Dispensary Registration Certificate

A. Except as provided in R9-17-324, a dispensary may not transfer or assign the dispensary registration certificate.

B. A dispensary may change the location of the:
   1. Dispensary:
      a. If the dispensary was allocated a dispensary registration certificate on or after April 1, 2020, according to A.R.S. § 36-2803.01(D); and
      b. If the dispensary was allocated a dispensary registration certificate before April 1, 2020:
         i. Within the first three years after the Department issued the dispensary’s registration certificate, to another location in the geographic area where the dispensary is located; or
         ii. After the first three years after the Department issued a dispensary registration certificate to the dispensary, to another location in the state; or
2. Dispensary’s cultivation site to another location in the state.

C. A dispensary or the dispensary’s cultivation site shall not cultivate, manufacture, distribute, dispense, or sell medical marijuana at a new location until the dispensary submits an application for a change in a dispensary location or a change or addition of a cultivation site in R9-17-307 and the Department issues an amended dispensary registration certificate or an approval for the dispensary’s cultivation site’s new location to the dispensary.

R9-17-307. Applying to Change a Dispensary’s Location or Change or Add a Dispensary’s Cultivation Site

A. To change the location of a dispensary or the dispensary’s cultivation site or to add a cultivation site, the dispensary shall submit an application to the Department that includes:

1. The following information in a Department-provided format:
   a. The legal name of the dispensary;
   b. The registry identification number for the dispensary;
   c. Whether the request is for:
      i. A change of location for the dispensary,
      ii. A change of location for the dispensary’s cultivation site, or
      iii. An addition of a cultivation site;
   d. The current physical address of the dispensary or the dispensary’s cultivation site;
   e. The physical address of the proposed location for the dispensary or the dispensary’s cultivation site;
   f. The distance to the closest public school or private school from:
      i. The proposed location for the dispensary, or
      ii. The proposed location for the dispensary’s cultivation site;
   g. The name of the entity applying;
   h. If applicable, the anticipated date of the change of location;
   i. Whether the proposed dispensary or the dispensary’s proposed cultivation site is ready for an inspection by the Department;
   j. If the proposed dispensary or the dispensary’s proposed cultivation site is not ready for an inspection by the Department, the date the dispensary or the dispensary’s cultivation site will be ready for an inspection by the Department;
   k. An attestation that the information provided to the Department to apply for a change in location is true and correct; and
1. The signature of each principal officer and board member of the dispensary according to R9-17-301 and the date signed;

2. A copy of documentation issued by the local jurisdiction to the dispensary authorizing occupancy of the proposed building as a dispensary or location as the dispensary’s cultivation site, such as a certificate of occupancy, a special use permit, or a conditional use permit;

3. A sworn statement, signed by each principal officer and board member of the dispensary according to R9-17-301, certifying that the location of the proposed dispensary building or of the dispensary’s proposed cultivation site is in compliance with local zoning restrictions;

4. If the change in location is for the dispensary:
   a. A site plan drawn to scale of the proposed dispensary location showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
   b. A floor plan drawn to scale of the building where the proposed dispensary is located showing the:
      i. Layout and dimensions of each room,
      ii. Name and function of each room,
      iii. Location of each hand washing sink,
      iv. Location of each toilet room,
      v. Means of egress,
      vi. Location of each video camera,
      vii. Location of each panic button, and
      viii. Location of natural and artificial lighting sources;

5. If the change in location is for the dispensary’s cultivation site or if adding a cultivation site:
   a. A site plan drawn to scale of the dispensary’s proposed cultivation site showing streets, property lines, buildings, parking areas, outdoor areas if applicable, fences, security features, fire hydrants if applicable, and access to water mains; and
   b. If applicable, a floor plan drawn to scale of each building used by the dispensary’s proposed cultivation site showing the:
      i. Layout and dimensions of each room,
      ii. Name and function of each room,
      iii. Location of each hand washing sink,
      iv. Location of each toilet room,
      v. Means of egress,
      vi. Location of each video camera,
vii. Location of each panic button, and
viii. Location of natural and artificial lighting sources; and

6. The applicable fee in R9-17-102 for applying for a change in location or the addition of a cultivation site.

B. If the information and documents submitted by the dispensary comply with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall issue an amended dispensary registration certificate that includes the new address of the new location and retains the expiration date of the previously issued dispensary registration certificate.

C. An application for a change in location of a dispensary or a dispensary’s cultivation site or the addition of a cultivation site may not be combined with an application for renewing a dispensary registration certificate. The Department shall process each application separately according to the applicable time-frame established in R9-17-107.

D. A dispensary shall submit written notification to the Department when the dispensary no longer uses a previously approved cultivation site.

R9-17-308. Renewing a Dispensary Registration Certificate
To renew a dispensary registration certificate, a dispensary that has an approval to operate a dispensary issued by the Department, shall submit to the Department, at least 30 calendar days before the expiration date of the dispensary’s current dispensary registration certificate, the following:

1. An application in a Department-provided format that includes:
   a. The legal name of the dispensary;
   b. The registry identification number for the dispensary;
   c. If the dispensary is a dual licensee, the marijuana establishment license number;
   d. The physical address of the dispensary;
   e. The name of the entity applying;
   f. Except as provided in R9-17-324(D), the name and license number of the dispensary’s medical director;
   g. The dispensary’s hours of operation during which the dispensary is available to dispense medical marijuana to qualifying patients and designated caregivers;
   h. The name, address, date of birth, and registry identification number of each:
      i. Principal officer,
      ii. Board member, and
      iii. Dispensary agent;
   i. For each principal officer or board member, whether the principal officer or board member:
i. Has served as a principal officer or board member for a dispensary that had the dispensary registration certificate revoked,
ii. Is a physician currently providing written certifications for qualifying patients,
iii. Is a law enforcement officer, or
iv. Is employed by or a contractor of the Department;
j. The dispensary’s Transaction Privilege Tax Number issued by the Arizona Department of Revenue;
k. Whether the dispensary agrees to allow the Department to submit supplemental requests for information;
l. An attestation that the information provided to the Department to renew the dispensary registration certificate is true and correct; and
m. The signature of each principal officer and board member of the dispensary according to R9-17-301 and the date signed;

2. If the application is for renewing a dispensary registration certificate that was initially issued within the previous 12 months, a copy of the dispensary’s approval to operate a dispensary issued by the Department;

3. Except as specified in R9-17-324(E):
   a. A copy of an annual financial statement for the previous two years, or for the portion of the previous two years the dispensary was operational, prepared according to generally accepted accounting principles; and
   b. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (3)(a); and

4. The applicable fee in R9-17-102 for applying to renew a dispensary registration certificate.

R9-17-309. Inspections

A. Submission of an application for a dispensary registration certificate constitutes permission for entry to and inspection of the dispensary and, if applicable, the dispensary’s cultivation site.

B. Except as provided in subsection (D), an onsite inspection of a dispensary or the dispensary’s cultivation site shall occur at a date and time agreed to by the dispensary and the Department that is no later than five working days after the date the Department submits a written request to the dispensary to schedule the certification or compliance inspection, unless the Department agrees to a later date and time.

C. The Department shall not accept allegations of a dispensary’s or a dispensary’s cultivation site’s noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter from an anonymous source.
D. If the Department receives an allegation of a dispensary’s or a dispensary’s cultivation site’s noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter, the Department may conduct an unannounced inspection of the dispensary or the dispensary’s cultivation site.

E. If the Department identifies a violation of A.R.S. Title 36, Chapter 28.1 or this Chapter during an inspection of a dispensary or the dispensary’s cultivation site:
   1. The Department shall provide the dispensary with a written notice that includes the specific rule or statute that was violated; and
   2. The dispensary shall notify the Department in writing, with a postmark date within 20 working days after the date of the notice of violations, identifying the corrective actions taken and the date of the correction.

R9-17-310. Administration

A. A dispensary shall:
   1. Ensure that the dispensary is operating and available to dispense medical marijuana and marijuana products to qualifying patients and designated caregivers:
      a. At least 30 hours weekly between the hours of 7:00 a.m. and 10:00 p.m.; and
      b. For a dispensary with a dispensary registration certificate issued on or after April 1, 2020, within 18 months after receiving the dispensary registration certificate;
   2. Develop, document, and implement policies and procedures regarding:
      a. Job descriptions and employment contracts, including:
         i. Personnel duties, authority, responsibilities, and qualifications;
         ii. Personnel supervision;
         iii. Training in and adherence to confidentiality requirements;
         iv. Periodic performance evaluations; and
         v. Disciplinary actions;
      b. Business records, such as manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers;
      c. Inventory control, including:
         i. Tracking;
         ii. Packaging;
         iii. Accepting marijuana from qualifying patients and designated caregivers;
         iv. Acquiring marijuana or marijuana products from other dispensaries;
         v. Providing marijuana or marijuana products to another dispensary; and
vi. Either:
   (1) Providing samples of marijuana or marijuana products to a laboratory for testing, or
   (2) Allowing a laboratory agent access to medical marijuana or marijuana product to
       collect samples;

d. Laboratory testing, including:
   i. The analytes, including possible contaminants, to be tested for;
   ii. The process for separating a batch of marijuana or of a marijuana product until laboratory
       testing has been completed and testing results received by the dispensary;
   iii. The process for collecting samples of medical marijuana or a marijuana product for
       laboratory testing, including:
       (1) The amount to be collected from each batch,
       (2) The method for ensuring that a sample collected is representative of the batch,
       (3) The packaging of the sample,
       (4) The method for documenting chain of custody for the sample, and
       (5) Methods to deter tampering with the sample and to determine whether tampering has
           occurred;
   vi. The process for submitting a sample of medical marijuana or a marijuana product to a
       laboratory agent or laboratory for testing;

e. Remediation, including:
   i. Criteria for when a batch of medical marijuana or marijuana product can be remediated;
   ii. The process by which each type of medical marijuana or marijuana product is remediated,
       including the methods for remediation and subsequent retesting; and
   iii. Documentation of the remediation process;

f. Disposal of medical marijuana or a marijuana product, including:
   i. Destroying a batch of marijuana or a marijuana product that does not meet the requirements
      in Table 3.1 Analytes
      and documenting the destruction;
   ii. Submitting marijuana that is not usable marijuana to a local law enforcement agency and
       documenting the submission; or
iii. Otherwise disposing of marijuana or a marijuana product such that the marijuana or marijuana product is unrecognizable or cannot otherwise be used and documenting the method of disposal, the laboratory agent overseeing the disposal, and the date of disposal;
g. Qualifying patient records, including purchases, denials of sale, any delivery options, confidentiality, and retention; and
h. Patient education and support, including the development and distribution of materials on:
i. Availability of different strains of marijuana and the purported effects of the different strains;
ii. Information about the purported effectiveness of various methods, forms, and routes of medical marijuana administration;
iii. Information about laboratory testing, the analytes for which the dispensary receives testing results, the right to receive a copy of the final report of testing specified in R9-17-404.06 upon request, and how to read and understand the final report of testing;
iv. Methods of tracking the effects on a qualifying patient of different strains and forms of marijuana; and
v. Prohibition on the smoking of medical marijuana in public places;

3. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request;
4. Review dispensary policies and procedures at least once every 12 months from the issue date of the dispensary registration certificate and update as needed;
5. Except as provided in R9-17-324(D), employ or contract with a medical director;
6. Except as provided in R9-17-324(C), ensure that each dispensary agent has the dispensary agent’s registry identification card in the dispensary agent’s immediate possession when the dispensary agent is:
a. Working or providing volunteer services at the dispensary or the dispensary’s cultivation site,
or
b. Transporting marijuana for the dispensary;
7. Except as provided in R9-17-324(C), ensure that a dispensary agent accompanies any individual other than another dispensary agent associated with the dispensary when the individual is present in the enclosed, locked facility where marijuana is cultivated by the dispensary;
8. Except as provided in R9-17-324(C), not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate to:
a. Serve as a principal officer or board member for the dispensary,
b. Serve as the medical director for the dispensary,
c. Be employed by the dispensary, or

d. Provide volunteer services at or on behalf of the dispensary;

9. Provide written notice to the Department, including the date of the event, within 10 working days after the date, when a dispensary agent no longer:

a. Serves as a principal officer or board member for the dispensary,

b. Serves as the medical director for the dispensary,

c. Is employed by the dispensary, or

d. Provides volunteer services at or on behalf of the dispensary;

10. Document and report any loss or theft of marijuana from the dispensary to the appropriate law enforcement agency;

11. Maintain copies of any documentation required in this Chapter for at least 12 months after the date on the documentation and provide copies of the documentation to the Department for review upon request;

12. Post the following information in a place that can be viewed by individuals entering the dispensary:

a. If applicable, the dispensary’s approval to operate;

b. The dispensary’s registration certificate;

c. Except as provided in R9-17-324(D), the name of the dispensary’s medical director and the medical director’s professional license number on a sign at least 20 centimeters by 30 centimeters;

d. The hours of operation during which the dispensary will dispense medical marijuana to a qualifying patient or a designated caregiver;

e. A sign in a Department-provided format that contains the following language:

i. “WARNING: There may be potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding,” and

ii. “WARNING: Use of marijuana during pregnancy may result in a risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report;” and

f. A sign stating that a qualifying patient has the right to receive the results of laboratory testing of medical marijuana or a marijuana product; and

13. Except as provided in R9-17-324(D):

a. Not lend any part of the dispensary’s income or property without receiving adequate security and a reasonable rate of interest,

b. Not purchase property for more than adequate consideration in money or cash equivalent,
c. Not pay compensation for salaries or other compensation for personal services that is in excess of a reasonable allowance,

d. Not sell any part of the dispensary’s property or equipment for less than adequate consideration in money or cash equivalent, and

e. Not engage in any other transaction that results in a substantial diversion of the dispensary’s income or property.

B. If a dispensary cultivates marijuana, the dispensary shall cultivate the marijuana in an enclosed, locked facility.

R9-17-311. Submitting an Application for a Dispensary Agent Registry Identification Card

Except as provided in R9-17-107(F) or R9-17-324(C), to obtain a dispensary agent registry identification card for an individual serving as a principal officer or board member for the dispensary, employed by the dispensary, or providing volunteer services at or on behalf of the dispensary, the dispensary shall submit to the Department the following for each individual:

1. An application in a Department-provided format that includes:
   a. The individual’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The individual’s residence address and mailing address;
   c. The county where the individual resides;
   d. The individual’s date of birth;
   e. The identifying number on the applicable card or document in subsection (5)(a) through (e);
   f. The name and registry identification number of the dispensary; and
   g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary’s behalf and the date signed;

2. An attestation signed and dated by the individual that the individual has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

3. One of the following:
   a. A statement that the individual does not currently hold a valid registry identification card, or
   b. The assigned registry identification number for the individual for each valid registry identification card currently held by the individual;

4. A statement in a Department-provided format signed by the individual pledging not to divert marijuana to any other individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A copy of the individual’s:
a. Arizona driver’s license issued on or after October 1, 1996;
b. Arizona identification card issued on or after October 1, 1996;
c. Arizona registry identification card;
d. Photograph page in the individual’s U.S. passport; or
e. Arizona driver’s license or identification card issued before October 1, 1996 and one of the
   following for the individual:
   i. Birth certificate verifying U.S. citizenship,
   ii. U.S. Certificate of Naturalization, or
   iii. U.S. Certificate of Citizenship;
6. A current photograph of the individual;
7. For the Department’s criminal records check authorized in A.R.S. §§ 36-2804.01 and 36-2804.05:
   a. The individual’s fingerprints on a fingerprint card that includes:
      i. The individual’s first name; middle initial, if applicable; and last name;
      ii. The individual’s signature;
      iii. If different from the individual, the signature of another individual physically rolling the
          individual’s fingerprints;
      iv. The individual’s address;
      v. If applicable, the individual’s surname before marriage and any names previously used by
         the individual;
      vi. The individual’s date of birth;
      vii. The individual’s Social Security number;
      viii. The individual’s citizenship status;
      ix. The individual’s gender;
      x. The individual’s race;
      xi. The individual’s height;
      xii. The individual’s weight;
      xiii. The individual’s hair color;
      xiv. The individual’s eye color; and
      xv. The individual’s place of birth; or
   b. If the individual’s fingerprints and information required in subsection (7)(a) were submitted to
      the Department as part of an application for a designated caregiver registry identification card,
      dispensary agent registry identification card for another dispensary, or laboratory agent registry
      identification card within the previous six months, the registry identification number on the
      registry identification card issued to the individual as a result of the application; and
8. The applicable fee in R9-17-102 for applying for a dispensary agent registry identification card.

**R9-17-312. Submitting an Application to Renew a Dispensary Agent’s Registry Identification Card**

To renew a dispensary agent’s registry identification card, a dispensary shall submit to the Department, at least 30 calendar days before the expiration of the dispensary agent’s registry identification card, the following:

1. An application in a Department-provided format that includes:
   a. The dispensary agent’s first name; middle initial, if applicable; last name; and suffix, if applicable;
   b. The dispensary agent’s residence address and mailing address;
   c. The county where the dispensary agent resides;
   d. The dispensary agent’s date of birth;
   e. The registry identification number on the dispensary agent’s current registry identification card;
   f. The name and registry identification number of the dispensary; and
   g. The signature of the individual in R9-17-304(C)(1)(d) or of a principal officer or board member, as applicable, designated to submit dispensary agent applications on the dispensary’s behalf and the date signed;

2. An attestation signed and dated by the dispensary agent that the dispensary agent has not been convicted of an excluded felony offense as defined in A.R.S. § 36-2801;

3. If the dispensary agent’s name in subsection (1)(a) is not the same name as on the dispensary agent’s current registry identification card, one of the following with the dispensary agent’s new name:
   a. An Arizona driver’s license,
   b. An Arizona identification card, or
   c. The photograph page in the dispensary agent’s U.S. passport;

4. A statement in a Department-provided format signed by the dispensary agent pledging not to divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant to A.R.S. Title 36, Chapter 28.1;

5. A current photograph of the dispensary agent;

6. For the Department’s criminal records check authorized in A.R.S. § 36-2804.05:
   a. The dispensary agent’s fingerprints on a fingerprint card that includes:
      i. The dispensary agent’s first name; middle initial, if applicable; and last name;
ii. The dispensary agent’s signature;

iii. If different from the dispensary agent, the signature of the individual physically rolling the dispensary agent’s fingerprints;

iv. The dispensary agent’s address;

v. If applicable, the dispensary agent’s surname before marriage and any names previously used by the dispensary agent;

vi. The dispensary agent’s date of birth;

vii. The dispensary agent’s Social Security number;

viii. The dispensary agent’s citizenship status;

ix. The dispensary agent’s gender;

x. The dispensary agent’s race;

xi. The dispensary agent’s height;

xii. The dispensary agent’s weight;

xiii. The dispensary agent’s hair color;

xiv. The dispensary agent’s eye color; and

xv. The dispensary agent’s place of birth; or

b. If the dispensary agent’s fingerprints and information required in subsection (6)(a) were submitted to the Department as part of an application for a designated caregiver registry identification card, dispensary agent registry identification card for another dispensary, or laboratory agent registry identification card within the previous six months, the registry identification number on the registry identification card issued to the dispensary agent as a result of the application; and

7. The applicable fee in R9-17-102 for applying to renew a dispensary agent’s registry identification card.

R9-17-313. Medical Director

A. Except as provided in R9-17-324(D), a dispensary shall appoint an individual who is a physician to function as a medical director.

B. During a dispensary’s hours of operation, a medical director or an individual who is a physician and is designated by the medical director to serve as medical director in the medical director’s absence is:

1. Onsite; or

2. Able to be contacted by any means possible, such as by telephone or pager.

C. A medical director shall:
1. Develop and provide training to the dispensary’s dispensary agents at least once every 12 months from the initial date of the dispensary’s registration certificate on the following subjects:
   a. Guidelines for providing information to qualifying patients related to risks, benefits, and side effects associated with medical marijuana;
   b. Guidelines for providing support to qualifying patients related to the qualifying patient’s self-assessment of the qualifying patient’s symptoms, including a rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, and agitation;
   c. Recognizing signs and symptoms of substance abuse; and
   d. Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana; and

2. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary.

D. A medical director shall provide oversight for the development and dissemination of:

1. Educational materials for qualifying patients and designated caregivers that include:
   a. Alternative medical options for the qualifying patient’s debilitating medical condition;
   b. Information about possible side effects of and contraindications for medical marijuana including possible impairment with use and operation of a motor vehicle or heavy machinery, when caring for children, or of job performance;
   c. Guidelines for notifying the physician who provided the written certification for medical marijuana if side effects or contraindications occur;
   d. A description of the potential for differing strengths of medical marijuana strains and products;
   e. Information about potential drug-to-drug interactions, including interactions with alcohol, prescription drugs, non-prescription drugs, and supplements;
   f. Techniques for the use of medical marijuana and marijuana paraphernalia;
   g. Information about different methods, forms, and routes of medical marijuana administration;
   h. Signs and symptoms of substance abuse, including tolerance, dependency, and withdrawal; and
   i. A listing of substance abuse programs and referral information;

2. A system for a qualifying patient or the qualifying patient’s designated caregiver to document the qualifying patient’s pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, or agitation that includes:
   a. A log book, maintained by the qualifying patient and or the qualifying patient’s designated caregiver, in which the qualifying patient or the qualifying patient’s designated caregiver may track the use and effects of specific medical marijuana strains and products;
b. A rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscles spasms, and agitation;
c. Guidelines for the qualifying patient’s self-assessment or, if applicable, assessment of the qualifying patient by the qualifying patient’s designated caregiver; and
d. Guidelines for reporting usage and symptoms to the physician providing the written certification for medical marijuana and any other treating physicians; and

3. Policies and procedures for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana.

E. A medical director for a dispensary shall not provide a written certification for medical marijuana for any qualifying patient.

R9-17-314. Dispensing Medical Marijuana

A. Before a dispensary agent dispenses medical marijuana or a marijuana product to a qualifying patient or a designated caregiver, the dispensary agent shall:

1. Verify the qualifying patient’s or the designated caregiver’s identity,
2. Offer any appropriate patient education or support materials,
3. Make available the results of testing of the medical marijuana or marijuana product required in R9-17-317.01(A), if requested by the qualifying patient or designated caregiver,
4. Enter the qualifying patient’s or designated caregiver’s registry identification number on the qualifying patient’s or designated caregiver’s registry identification card into the medical marijuana electronic verification system,
5. Verify the validity of the qualifying patient’s or designated caregiver’s registry identification card,
6. Verify that the amount of medical marijuana or marijuana product the qualifying patient or designated caregiver is requesting would not cause the qualifying patient to exceed the limit on obtaining no more than two and one-half ounces of medical marijuana during any 14-calendar-day period, and
7. Enter the following information into the medical marijuana electronic verification system for the qualifying patient or designated caregiver:
   a. The amount of medical marijuana dispensed,
   b. Whether the medical marijuana was dispensed to the qualifying patient or to the qualifying patient’s designated caregiver,
   c. The date and time the medical marijuana was dispensed,
   d. The dispensary agent’s registry identification number, and
   e. The dispensary’s registry identification number.
B. A dispensary shall ensure that medical marijuana or a marijuana product provided by the dispensary to a qualifying patient or a designated caregiver is dispensed in a container made of material that will not react with or leach into the medical marijuana or marijuana product.

R9-17-315. Qualifying Patient Records

A. A dispensary shall ensure that:

1. A qualifying patient record is established and maintained for each qualifying patient who obtains medical marijuana or a marijuana product from the dispensary;

2. An entry in a qualifying patient record:
   a. Is recorded only by a dispensary agent authorized by dispensary policies and procedures to make an entry,
   b. Is dated and signed by the dispensary agent,
   c. Includes the dispensary agent’s registry identification number, and
   d. Is not changed to make the initial entry illegible;

3. If an electronic signature is used to sign an entry, the dispensary agent whose signature the electronic code represents is accountable for the use of the electronic signature;

4. A qualifying patient record is only accessed by a dispensary agent authorized by dispensary policies and procedures to access the qualifying patient record;

5. A qualifying patient record is provided to the Department for review upon request;

6. A qualifying patient record is protected from loss, damage, or unauthorized use; and

7. A qualifying patient record is maintained for five years after the date of the qualifying patient’s or, if applicable, the qualifying patient’s designated caregiver’s last request for medical marijuana from the dispensary.

B. If a dispensary maintains qualifying patient records electronically, the dispensary shall ensure that:

1. There are safeguards to prevent unauthorized access, and

2. The date and time of an entry in a qualifying patient record is recorded electronically by an internal clock.

C. A dispensary shall ensure that the qualifying patient record for a qualifying patient who requests or whose designated caregiver on behalf of the qualifying patient requests medical marijuana or a marijuana product from the dispensary contains:

1. Qualifying patient information that includes:
   a. The qualifying patient’s name;
   b. The qualifying patient’s date of birth; and
   c. The name of the qualifying patient’s designated caregiver, if applicable;
2. Documentation of any patient education and support materials provided to the qualifying patient or
the qualifying patient’s designated caregiver, including a description of the materials and the date
the materials were provided; and
3. For each time the qualifying patient requests and does not obtain medical marijuana or a marijuana
product or, if applicable, the designated caregiver requests on behalf of the qualifying patient and
does not obtain medical marijuana or a marijuana product from the dispensary, the following:
   a. The date,
   b. The name and registry identification number of the individual who requested the medical
      marijuana or marijuana product, and
   c. The dispensary’s reason for refusing to provide the medical marijuana or marijuana product.

R9-17-316. Inventory Control System
A. A dispensary shall designate in writing a dispensary agent who has oversight of the dispensary’s
   medical marijuana inventory control system.
B. A dispensary shall only acquire marijuana from:
   1. The dispensary’s cultivation site,
   2. Another dispensary or another dispensary’s cultivation site,
   3. A qualifying patient authorized by the Department to cultivate marijuana, or
   4. A designated caregiver authorized by the Department to cultivate marijuana.
C. A dispensary shall establish and implement an inventory control system for the dispensary’s medical
   marijuana and marijuana products that documents:
   1. The following amounts:
      a. Each day’s beginning inventory of medical marijuana and marijuana products,
      b. Acquisitions according to subsection (B),
      c. Medical marijuana harvested by the dispensary,
      d. Medical marijuana and marijuana products provided to another dispensary,
      e. Medical marijuana and marijuana products dispensed to a qualifying patient or designated
caregiver,
      f. Medical marijuana and marijuana products submitted to a laboratory for testing according to
         R9-17-317.01,
      g. Medical marijuana or marijuana products that were disposed of, and
      h. The day’s ending medical marijuana and marijuana products inventory;
2. For acquiring medical marijuana from a qualifying patient or designated caregiver:
   a. A description of the medical marijuana acquired including the amount and strain,
b. The name and registry identification number of the qualifying patient or designated caregiver who provided the medical marijuana,
d. The date of acquisition;
3. For acquiring medical marijuana or a marijuana product from another dispensary:
 a. A description of the medical marijuana or marijuana product acquired including:
   i. The amount, batch number, and strain of the medical marijuana or marijuana product;
   ii. For a marijuana product, the ingredients in order of abundance; and
   iii. For an edible marijuana product infused with medical marijuana or a marijuana product:
       1. The date of manufacture,
       2. The total weight of the edible marijuana product, and
       3. The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible marijuana product;
 b. The name and registry identification number of the dispensary providing the medical marijuana or marijuana product;
 c. The name and registry identification number of the dispensary agent providing the medical marijuana or marijuana product;
 d. The name and registry identification number of the dispensary agent receiving the medical marijuana or marijuana product on behalf of the dispensary; and
e. The date of acquisition;
4. For each batch of marijuana cultivated:
 a. The batch number;
 b. Whether the batch originated from marijuana seeds or marijuana cuttings;
 c. The origin and strain of the marijuana seeds or marijuana cuttings planted;
 d. The number of marijuana seeds or marijuana cuttings planted;
 e. The date the marijuana seeds or cuttings were planted;
 f. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers used in the cultivation;
 g. The number of plants grown to maturity; and
 h. Harvest information including:
   i. Date of harvest,
   ii. Final processed usable marijuana yield weight, and
iii. Name and registry identification number of the dispensary agent responsible for the harvest;

5. For providing medical marijuana or a marijuana product to another dispensary:
   a. A description of the medical marijuana or marijuana product provided including:
      i. The amount, batch number, and strain of the medical marijuana or marijuana product;
      ii. For a marijuana product, the ingredients in order of abundance; and
      iii. For an edible marijuana product infused with medical marijuana or a marijuana product:
         (1) The date of manufacture,
         (2) The total weight of the edible marijuana product, and
         (3) The estimated amount and batch number of the medical marijuana or marijuana product infused in the edible marijuana product;
   b. The name and registry identification number of the other dispensary;
   c. The name and registry identification number of the dispensary agent who received the medical marijuana or marijuana product on behalf of the other dispensary; and
   d. The date the medical marijuana or marijuana product was provided;

6. For submitting marijuana or marijuana products to a laboratory agent or laboratory for testing:
   a. The amount, strain, and batch number of the marijuana or marijuana product submitted;
   b. The name and registry identification number of the laboratory;
   c. The name and registry identification number of the laboratory agent who received the marijuana or marijuana product on behalf of the laboratory; and
   d. The date the marijuana or marijuana product was submitted to the laboratory; and

7. For disposal of medical marijuana or a marijuana product that is not to be dispensed or used for making a marijuana product:
   a. Description of and reason for the medical marijuana or marijuana product being disposed of including, if applicable:
      i. The number of failed or other unusable plants, and
      ii. The results of laboratory testing;
   b. Date of disposal;
   c. Method of disposal; and
   d. Name and registry identification number of the dispensary agent responsible for the disposal.

D. The individual designated in subsection (A) shall conduct and document an audit of the dispensary’s inventory that is accounted for according to generally accepted accounting principles at least once every 30 calendar days.
1. If the audit identifies a reduction in the amount of medical marijuana or a marijuana product in the dispensary’s inventory not due to documented causes, the dispensary shall determine and document where the loss has occurred and take and document corrective action.

2. If the reduction in the amount of medical marijuana or a marijuana product in the dispensary’s inventory is due to suspected criminal activity by a dispensary agent, the dispensary shall report the dispensary agent to the Department and to the local law enforcement authorities.

E. A dispensary shall:
   1. Maintain the documentation required in subsections (C) and (D) at the dispensary for at least five years after the date on the document, and
   2. Provide the documentation required in subsections (C) and (D) to the Department for review upon request.

R9-17-317. Product Labeling

A. A dispensary shall ensure that medical marijuana or a marijuana product provided by the dispensary to a qualifying patient or a designated caregiver is labeled with:
   1. The dispensary’s registry identification number;
   2. The amount, strain, and batch number of the medical marijuana or marijuana product;
   3. The form of the medical marijuana or marijuana product;
   4. As applicable, the weight of the medical marijuana or marijuana product;
   5. In compliance with Table 3.1 Analytes, the potency of the medical marijuana or marijuana product, based on laboratory testing results, including the number of milligrams per designated unit or percentage of:
      a. Total tetrahydrocannabinol, reported according to R9-17-404.03(S)(2)(a);
      b. Total cannabidiol, reported according to R9-17-404.03(S)(2)(b); and
      c. Any other cannabinoid for which the dispensary is making a claim related to the effect of the cannabinoid on the human body;
   6. The following statement: “ARIZONA DEPARTMENT OF HEALTH SERVICES’ WARNING: Marijuana use can be addictive and can impair an individual’s ability to drive a motor vehicle or operate heavy machinery. Marijuana smoke contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, and lung infection. KEEP OUT OF REACH OF CHILDREN”;
   7. If not cultivated by the dispensary, whether the medical marijuana was obtained from a qualifying patient, a designated caregiver, or another dispensary;
8. If not infused or prepared for sale by the dispensary, whether the marijuana product was obtained from another dispensary;
9. For a marijuana product:
   a. The ingredients in order of abundance; and
   b. If the marijuana product contains ethanol, the percentage of ethanol in the marijuana product;
10. The date of manufacture, harvest, or sale; and
11. The registry identification number of the qualifying patient.

B. If a dispensary provides medical marijuana cultivated, or a marijuana product infused or prepared for sale, by the dispensary to another dispensary, the dispensary shall ensure that:
1. The medical marijuana or marijuana product is labeled with:
   a. The dispensary’s registry identification number;
   b. The amount, strain, and batch number of the medical marijuana or marijuana product; and
   c. The date of harvest or sale; and
2. A copy of laboratory testing results for the medical marijuana or marijuana product is provided to the receiving dispensary.

C. A dispensary shall ensure that medical marijuana or a marijuana product being submitted to a laboratory for testing is labeled according to requirements in R9-17-317.01(B)(5).

R9-17-317.01. Analysis of Medical Marijuana or a Marijuana Product
A. Before offering a batch of medical marijuana or of a marijuana product for sale or dispensing to a qualifying patient or designated caregiver, a dispensary shall ensure that:
1. Except as provided in subsection (A)(2), each batch of medical marijuana or marijuana product is tested in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes; and
2. Each batch of a marijuana product is tested according to requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes for, as applicable:
   a. At least potency and microbial contaminants other than mycotoxins if the marijuana product was prepared from another marijuana product, such as a concentrate or tincture, that is in compliance with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, using none of the following:
      i. A temperature above which any analyte could chemically decompose or react with a component of the marijuana product;
      ii. A pressure above which any analyte could chemically decompose or react with a component of the marijuana product;
iii. A process by which any analyte in the marijuana product that is in compliance with
requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes may be further
concentrated; or
iv. A solvent other than water; or
b. All analytes except ethanol if the marijuana product is intended to contain ethanol.

B. A dispensary shall ensure that:
1. Until laboratory testing has been completed and testing results received by the dispensary that
comply with requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, a batch of
marijuana or of a marijuana product is stored in a location away from medical marijuana and
marijuana products offered for dispensing;
2. Only one sample of each batch of medical marijuana or marijuana product is collected according
to ANSI/ASQ Standard Z1.4 (2018), General Inspection Level II, incorporated by reference,
including no future editions, and available at https://asq.org/quality-resources/z14-z19, including:
a. Use, as applicable, of one of the following sampling methods:
i. Top, middle, and bottom sampling using a sample thief, a device consisting of two nested
tubes with one or more aligned slots through which a sample may be collected and then
sealed into the inner tube by rotating the outer tube;
ii. Star pattern sampling from the top, middle, and bottom of each storage container;
iii. Collecting discrete incremental units of a batch, such as every tenth unit or every twentieth
drop; or
iv. Quartering until the sample reaches the size specified in subsection (B)(3); and
b. For sampling methods specified in subsections (B)(2)(a)(i) through (iii), quartering the volume
of the aggregated portions collected to obtain the sample size specified in subsection (B)(3);
3. The size of the sample provided to a laboratory is sufficient for testing and, if necessary, retesting;
4. Each sample in subsection (B)(3) is packaged in a container made of:
a. The same material that would be used for dispensing, or
b. Another material that will not react with or leach into the sample;
5. Each packaged sample is labeled with the:
a. The dispensary’s registry identification number;
b. The amount, strain, and batch number of the medical marijuana or marijuana product;
c. The storage temperature for the medical marijuana or marijuana product; and
d. The date of sampling;
6. A packaged sample in subsection (B)(4) is submitted to a laboratory that:
a. Has a laboratory registration certificate issued by the Department, and
b. Is approved for testing by the Department for an analyte for which testing is being requested;

7. Except as specified in subsections (A)(2) and (C)(1) or (3)(b), as applicable, the samples in subsection (B)(4) are tested for each analyte specified in Table 3.1 Analytes by a laboratory that is approved by the Department for testing the analyte;

8. Only batches of marijuana or marijuana products for which laboratory testing results in subsection (B)(7) are in compliance with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes are offered for sale or dispensing; and

9. Except as provided in subsection (C), any batch of marijuana or marijuana product that does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes is remediated, if applicable, or destroyed according to policies and procedures.

C. If a dispensary receives a final report of testing, specified in R9-17-404.06(B)(3), from a laboratory that indicates that a batch of marijuana or marijuana product does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, the dispensary:

1. Within seven days after receiving the final report of testing, may request retesting of the remaining portion of the sample in subsection (B)(4) for all analytes that do not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes by a second, independent laboratory that is approved by the Department for testing the analytes;

2. If the final report of testing from the second, independent laboratory indicates that any analyte tested for according to subsection (C)(1) does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, shall remediate, if applicable, or destroy the batch of marijuana or marijuana product according to policies and procedures;

3. If the final report of testing from the second, independent laboratory indicates that all analytes tested for according to subsection (C)(1) comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes:
   a. Shall ensure that the batch of medical marijuana or marijuana product is not offered for sale or dispensing; and
   b. May request retesting of the remaining portion of the sample in subsection (B)(4) for the analytes that do not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes by a third, independent laboratory that is approved by the Department for testing the analytes; and

4. If the dispensary requested retesting of the remaining portion of the sample in subsection (B)(4) for an analyte by a third, independent laboratory according to subsection (C)(3)(b):
a. If the final report of testing from the third, independent laboratory indicates that the analyte tested for according to subsection (C)(3) complies with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, may offer the batch of medical marijuana or marijuana product for sale or dispensing; and

b. If the final report of testing from the third, independent laboratory indicates that an analyte tested for according to subsection (C)(3) does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes, shall remediate, if applicable, or destroy the batch of medical marijuana or marijuana product according to policies and procedures.

D. A dispensary shall ensure that remediation of a batch of marijuana or of a marijuana product that has undergone laboratory testing and does not comply with the requirements in R9-17-404.03, R9-17-404.04, and Table 3.1 Analytes:
   1. Is performed according to policies and procedures,
   2. Uses a method that is appropriate to address an analyte not in compliance with Table 3.1 Analytes, and
   3. Does not introduce or produce a substance in a concentration that is known to be harmful to humans.

E. If a batch of medical marijuana or a marijuana product is remediated, a dispensary shall submit samples from the remediated batch for laboratory testing according to subsection (B).

F. A dispensary shall provide to the Department upon request a sample of the dispensary’s inventory of medical marijuana or a marijuana product of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana or marijuana product.

### Table 3.1. Analytes

**Key:**
- CAS Number = Chemical Abstract Services Registry number
- CFU = Colony-forming unit, a method to estimate the number of viable bacteria or fungal cells in a sample
- * = Testing for the analyte required beginning May 1, 2021

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Contaminants</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Escherichia coli</em></td>
<td>100 CFU/g</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td><em>Salmonella spp.</em></td>
<td>Detectable in 1 gram</td>
<td>Destroy</td>
</tr>
</tbody>
</table>
**Aspergillus flavus**  
**Aspergillus fumigatus**  
**Aspergillus niger**  
**Aspergillus terreus**  

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Mycotoxins:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aflatoxin B1, B2, G1, and G2</td>
<td>20 µg/kg (ppb) of total aflatoxins</td>
<td>Destroy</td>
</tr>
<tr>
<td>Ochratoxin A</td>
<td>20 µg/kg (ppb) of ochratoxin</td>
<td>Destroy</td>
</tr>
</tbody>
</table>

**B. Heavy Metals**

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arsenic</td>
<td>0.4 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td>Cadmium</td>
<td>0.4 ppm</td>
<td>Destroy</td>
</tr>
<tr>
<td>Lead</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Mercury</td>
<td>1.2 ppm</td>
<td></td>
</tr>
</tbody>
</table>

**C. Residual Solvents**

<table>
<thead>
<tr>
<th>Analyte</th>
<th>CAS Number</th>
<th>Maximum Allowable Concentration</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetone</td>
<td>67-64-1</td>
<td>1,000 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td>Acetonitrile</td>
<td>75-05-8</td>
<td>410 ppm</td>
<td></td>
</tr>
<tr>
<td>Benzene</td>
<td>71-43-2</td>
<td>2 ppm</td>
<td></td>
</tr>
<tr>
<td>Butanes (measured as the cumulative residue of n-butane)</td>
<td>106-97-8 and 75-28-5,</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Analyte</td>
<td>CAS Number</td>
<td>Maximum Allowable</td>
<td>Required Action</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>and iso-butane)</td>
<td>respectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloroform</td>
<td>67-66-3</td>
<td>60 ppm</td>
<td></td>
</tr>
<tr>
<td>Dichloromethane</td>
<td>75-09-2</td>
<td>600 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethanol</td>
<td>64-17-5</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethyl Acetate</td>
<td>141-78-6</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethyl Ether</td>
<td>60-29-7</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Heptane</td>
<td>142-82-5</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Hexanes (measured as the cumulative residue of n-hexane, 2-methylpentane, 3-methylpentane, 2,2-dimethylbutane, and 2,3-dimethylbutane)</td>
<td>110-54-3, 107-83-5, 96-14-0, 75-83-2, and 79-29-8, respectively</td>
<td>290 ppm</td>
<td></td>
</tr>
<tr>
<td>Isopropyl Acetate</td>
<td>108-21-4</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Methanol</td>
<td>67-56-1</td>
<td>3,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Pentanes (measured as the cumulative residue of n-pentane, iso-pentane, and neo-pentane)</td>
<td>109-66-0, 78-78-4, and 463-82-1, respectively</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>2-Propanol (IPA)</td>
<td>67-63-0</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Propane</td>
<td>74-98-6</td>
<td>5,000 ppm</td>
<td></td>
</tr>
<tr>
<td>Toluene</td>
<td>108-88-3</td>
<td>890 ppm</td>
<td></td>
</tr>
<tr>
<td>Xylenes (measured as the cumulative residue of 1,2-dimethylbenzene, 1,3-dimethylbenzene, and 1,4-dimethylbenzene, and the non-xylene, ethyl benzene)</td>
<td>1330-20-7 (95-47-6, 108-38-3, and 106-42-3, respectively, and 100-41-4)</td>
<td>2,170 ppm</td>
<td></td>
</tr>
</tbody>
</table>

**D. Pesticides, Fungicides, Growth Regulators**

<table>
<thead>
<tr>
<th>Analyte</th>
<th>CAS Number</th>
<th>Maximum Allowable</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compound</td>
<td>CAS Number</td>
<td>Concentration</td>
<td>Recommendation</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
<td>---------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>*Abamectin</td>
<td>71751-41-2</td>
<td>0.5 ppm</td>
<td>Remediate and retest, or Destroy</td>
</tr>
<tr>
<td>Acephate</td>
<td>30560-19-1</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Acequinocyl</td>
<td>57960-19-7</td>
<td>2.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Acetamiprid</td>
<td>135410-20-7</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Aldicarb</td>
<td>116-06-3</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Azoxystrobin</td>
<td>131860-33-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Bifenazate</td>
<td>149877-41-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Bifenthrin</td>
<td>82657-04-3</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Boscalid</td>
<td>188425-85-6</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Carbaryl</td>
<td>63-25-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Carbofuran</td>
<td>1563-66-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Chlorantraniliprole</td>
<td>500008-45-7</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Chlorfenapyr</td>
<td>122453-73-0</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Chlorpyrifos</td>
<td>2921-88-2</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Clofentezine</td>
<td>74115-24-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Cyfluthrin</td>
<td>68359-37-5</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Cypermethrin</td>
<td>52315-07-8</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Daminozide</td>
<td>1596-84-5</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*DDVP (Dichlorvos)</td>
<td>62-73-7</td>
<td>0.1 ppm</td>
<td></td>
</tr>
<tr>
<td>Diazinon</td>
<td>333-41-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Dimethoate</td>
<td>60-51-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Ethoprophos</td>
<td>13194-48-4</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Etofenprox</td>
<td>80844-07-1</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Etoxazole</td>
<td>153233-91-1</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Fenoxycarb</td>
<td>72490-01-8</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Fenpyroximate</td>
<td>134098-61-6</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>*Fipronil</td>
<td>120068-37-3</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Compound</td>
<td>CAS Number</td>
<td>Maximum Residue Limit</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Flonicamid</td>
<td>158062-67-0</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Fludioxonil</td>
<td>131341-86-1</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Hexythiazox</td>
<td>78587-05-0</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>Imazalil</td>
<td>35554-44-0</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Imidacloprid</td>
<td>138261-41-3</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Kresoxim-methyl</td>
<td>143390-89-0</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Malathion</td>
<td>121-75-5</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Metalaxyl</td>
<td>57837-19-1</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Methiocarb</td>
<td>2032-65-7</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Methomyl</td>
<td>16752-77-5</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>Myclobutanil</td>
<td>88671-89-0</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Naled</td>
<td>300-76-5</td>
<td>0.5 ppm</td>
<td></td>
</tr>
<tr>
<td>Oxamyl</td>
<td>23135-22-0</td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Paclobutrazol</td>
<td>76738-62-0</td>
<td>0.4 ppm</td>
<td></td>
</tr>
<tr>
<td>*Permethrins (measured as the cumulative residue of cis- and trans- isomers)</td>
<td></td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Phosmet</td>
<td>732-11-6</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Piperonyl_butoxide</td>
<td>51-03-6</td>
<td>2.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Prallethrin</td>
<td>23031-36-9</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Propiconazole</td>
<td>60207-90-1</td>
<td>0.4 ppm</td>
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</tr>
<tr>
<td>Propoxur</td>
<td>114-26-1</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Pyrethrins (measured as the cumulative residue of pyrethrin 1, cinerin 1 and jasmolin 1)</td>
<td></td>
<td>1.0 ppm</td>
<td></td>
</tr>
<tr>
<td>*Pyridaben</td>
<td>96489-71-3</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>*Spinosad</td>
<td>168316-95-8</td>
<td>0.2 ppm</td>
<td></td>
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<tr>
<td>Spiromesifen</td>
<td>283594-90-1</td>
<td>0.2 ppm</td>
<td></td>
</tr>
<tr>
<td>Analyte</td>
<td>Labelling</td>
<td>Required Action</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Tetrahydrocannabinolic acid (THC-A)</td>
<td>Label claim is not within +/- 20% of tested value</td>
<td>Revise label as necessary</td>
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<tr>
<td>Delta-9-tetrahydrocannabinol (Δ9-THC)</td>
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<tr>
<td>Cannabidiolic acid (CBD-A)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cannabidiol (CBD)</td>
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F. Herbicides

<table>
<thead>
<tr>
<th>Analyte</th>
<th>Maximum Allowable Contaminant</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pendimethalin</td>
<td>0.1 ppm</td>
<td>RemEDIATE and retest, or Destroy</td>
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</table>

R9-17-318. Security

A. Except as provided in R9-17-310(A)(7) or R9-17-324(C), a dispensary shall ensure that access into areas of the dispensary or the dispensary’s cultivation site where marijuana is cultivated, processed, manufactured, or stored is limited to the dispensary’s principal officers, board members, and authorized dispensary agents.

B. A dispensary agent may transport marijuana, marijuana plants, marijuana products, and marijuana paraphernalia between the dispensary and:
   1. The dispensary’s cultivation site,
   2. A qualifying patient,
3. Another dispensary, and
4. A laboratory that has a laboratory registration certificate issued by the Department.

C. Before transportation, a dispensary agent shall:
   1. Complete a trip plan that includes:
      a. The name of the dispensary agent in charge of transporting the marijuana;
      b. The date and start time of the trip;
      c. A description of the marijuana, marijuana plants, marijuana products, or marijuana paraphernalia being transported;
      d. Any anticipated stops during the trip, including the locations of the stop and arrival and departure time from the location; and
      e. The anticipated route of transportation; and
   2. Provide a copy of the trip plan in subsection (C)(1) to the dispensary.

D. During transportation, a dispensary agent shall:
   1. Carry a copy of the trip plan in subsection (C)(1) with the dispensary agent for the duration of the trip;
   2. Use a vehicle without any medical marijuana identification;
   3. Have a means of communication with the dispensary; and
   4. Ensure that the marijuana, marijuana plants, marijuana products, or marijuana paraphernalia are not visible.

E. After transportation, a dispensary agent shall enter the end time of the trip and any changes to the trip plan on the trip plan required in subsection (C)(1).

F. A dispensary shall:
   1. Maintain the documents required in subsection (C)(2) and (E) for at least two years after the date of the documentation;
   2. If transporting a sample to a laboratory for testing, provide a copy of the trip plan to the laboratory; and
   3. Provide a copy of the documents required in subsection (C)(2) and (E) to the Department for review upon request.

G. To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary’s cultivation site, the dispensary shall have the following:
   1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:
a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device;
b. Exterior lighting to facilitate surveillance;
c. Electronic monitoring including:
   i. At least one 19-inch or greater call-up monitor;
   ii. A printer capable of immediately producing a clear still photo from any video camera image;
   iii. Video cameras:
       (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and
       (2) Having a recording resolution of at least 704 x 480 or the equivalent;
   iv. A video camera at each point of sale location allowing for the identification of any qualifying patient or designated caregiver purchasing medical marijuana;
   v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions;
   vi. Storage of video recordings from the video cameras for at least 30 calendar days;
   vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; and
   viii. Sufficient battery backup for video cameras and recording equipment to support at least five minutes of recording in the event of a power outage; and
d. Panic buttons in the interior of each building; and

2. Policies and procedures:
   a. That restrict access to the areas of the dispensary that contain marijuana and, if applicable, the dispensary’s cultivation site to authorized individuals only;
   b. That provide for the identification of authorized individuals;
   c. That prevent loitering;
   d. For conducting electronic monitoring; and
   e. For the use of a panic button.

R9-17-319. Edible Food Products

A. A dispensary that prepares, sells, or dispenses marijuana-infused edible food products shall:
1. Before preparing, selling, or dispensing marijuana-infused edible food product obtain written authorization from the Department to prepare, sell, or dispense marijuana-infused edible food products;

2. If the dispensary prepares the marijuana-infused edible food products, ensure that the marijuana-infused edible food products are prepared according to the applicable requirements in 9 A.A.C. 8, Article 1;

3. If the marijuana-infused edible food products are not prepared at the dispensary, obtain and maintain at the dispensary a copy of the current written authorization to prepare marijuana-infused edible food products from the dispensary that prepares the marijuana-infused edible products; and

4. If a dispensary sells or dispenses marijuana-infused edible food products, ensure that the marijuana-infused edible food products are sold or dispensed according to applicable requirements in 9 A.A.C. 8, Article 1.

B. A dispensary is responsible for the content and quality of any edible food product sold or dispensed by the dispensary.

R9-17-320. Cleaning and Sanitation

A. A dispensary shall ensure that:

1. Any building or equipment used by a dispensary for the cultivation, harvest, preparation, packaging, storage, infusion, or sale of medical marijuana or marijuana products is maintained in a clean and sanitary condition;

2. Medical marijuana or marijuana products, in the process of production, preparation, manufacture, packing, storage, sale, distribution, or transportation, are protected from flies, dust, dirt, and all other contamination;

3. Refuse or waste products incident to the manufacture, preparation, packing, selling, distributing, or transportation of medical marijuana or marijuana products are removed from the building used as a dispensary and, if applicable, a building at the dispensary’s cultivation site at least once every 24 hours or more often as necessary to maintain a clean condition;

4. All trucks, trays, buckets, other receptacles, platforms, racks, tables, shelves, knives, saws, cleavers, other utensils, or the machinery used in moving, handling, cutting, chopping, mixing, canning, packaging, or other processes are cleaned daily;

5. Any equipment used in the preparation of marijuana products is clean, in good repair, and, if applicable, calibrated according to the manufacturer’s recommendations;

6. Any supplies used in the preparation of marijuana products, including flammable or volatile chemicals, are stored in a manner to avoid a hazardous condition from occurring; and
7. All stored marijuana products are securely covered.

B. A dispensary shall ensure that a dispensary agent at the dispensary or the dispensary’s cultivation site:
   1. Cleans the dispensary agent’s hands and exposed portions of the dispensary agent’s arms in a hand washing sink:
      a. Before preparing medical marijuana or marijuana products including working with food, equipment, and utensils;
      b. During preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;
      c. After handling soiled equipment or utensils;
      d. After touching bare human body parts other than the dispensary agent’s clean hands and exposed portions of arms; and
      e. After using the toilet room;
   2. If working directly with the preparation of medical marijuana or the infusion of marijuana into non-edible products:
      a. Keeps the dispensary agent’s fingernails trimmed, filed, and maintained so that the edges and surfaces are cleanable;
      b. Unless wearing intact gloves in good repair, does not have fingernail polish or artificial fingernails on the dispensary agent’s fingernails; and
      c. Wears protective apparel such as coats, aprons, gowns, or gloves to prevent contamination;
   3. Wears clean clothing appropriate to assigned tasks;
   4. Reports to the medical director any health condition experienced by the dispensary agent that may adversely affect the safety or quality of any medical marijuana or marijuana products with which the dispensary agent may come into contact; and
   5. If the medical director determines that a dispensary agent has a health condition that may adversely affect the safety or quality of the medical marijuana or marijuana products, is prohibited from direct contact with any medical marijuana, marijuana products, or equipment or materials for processing medical marijuana or marijuana products until the medical director determines that the dispensary agent’s health condition will not adversely affect the medical marijuana or marijuana products.

R9-17-321. Physical Plant

A. A dispensary or a dispensary’s cultivation site shall be located at least 500 feet from a private school or a public school that existed, as applicable:
   1. Before the date the dispensary submitted the initial dispensary registration certificate application,
   2. Before the date of an application to change the location of the dispensary, or
3. Before the date of an application to add a cultivation site.

B. A dispensary shall provide onsite parking or parking adjacent to the building used as the dispensary.

C. A building used as a dispensary or the location used as a dispensary’s cultivation site shall have:
   1. At least one toilet room;
   2. Each toilet room shall contain:
      a. A flushable toilet;
      b. Mounted toilet tissue;
      c. A sink with running water;
      d. Soap contained in a dispenser; and
      e. Disposable, single-use paper towels in a mounted dispenser or a mechanical air hand dryer;
   3. At least one hand washing sink not located in a toilet room;
   4. Designated storage areas for medical marijuana or materials used in direct contact with medical marijuana separate from storage areas for toxic or flammable materials; and
   5. If preparation or packaging of medical marijuana is done in the building, a designated area for the preparation or packaging that:
      a. Includes work space that can be sanitized, and
      b. Is only used for the preparation or packaging of medical marijuana.

D. For each commercial device used at a dispensary or the dispensary’s cultivation site, the dispensary shall:
   1. Ensure that the commercial device is licensed or certified pursuant to A.R.S. § 41-2091,
   2. Maintain documentation of the commercial device’s license or certification, and
   3. Provide a copy of the commercial device’s license or certification to the Department for review upon request.

R9-17-322. Denial or Revocation of a Dispensary Registration Certificate

A. The Department shall deny an application for a dispensary registration certificate or a renewal if:
   1. For an application for a dispensary registration certificate, the physical address of the building or, if applicable, the physical address of the dispensary’s cultivation site is within 500 feet of a private school or a public school that existed before the date the dispensary submitted the initial dispensary registration certificate application, before the date of an application to change the location of the dispensary, or before the date of an application to add a cultivation site;
   2. A principal officer or board member:
      a. Has been convicted of an excluded felony offense;
      b. Has served as a principal officer or board member for a dispensary that:
i. Had the dispensary registration certificate revoked, or
ii. Did not obtain an approval to operate the dispensary within the first year after the dispensary registration certificate was issued;

3. The application or the dispensary does not comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter.

B. The Department may deny an application for a dispensary registration certificate if a principal officer or board member of the dispensary provides false or misleading information to the Department.

C. The Department shall revoke a dispensary’s registration certificate if:

1. The dispensary:
   a. Operates before obtaining approval to operate a dispensary from the Department;
   b. Diverts marijuana to an entity other than:
      i. Another dispensary with a valid dispensary registration certificate issued by the Department,
      ii. A laboratory with a valid laboratory registration certificate issued by the Department,
      iii. A qualifying patient with a valid registry identification card issued by the Department,
      iv. A designated caregiver with a valid registry identification card issued by the Department,
      v. A dispensary agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a dispensary, or
      vi. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory;
   c. Acquires usable marijuana or mature marijuana plants from any entity other than another dispensary with a valid dispensary registration certificate issued by the Department, a qualifying patient with a valid registry identification card, or a designated caregiver with a valid registry identification card; or
   d. Acquires a marijuana product from any person other than another dispensary with a valid dispensary registration certificate issued by the Department; or

2. A principal officer or board member has been convicted of an excluded felony offense.

D. The Department may revoke a dispensary registration certificate if the dispensary does not:

1. Comply with the requirements in A.R.S. Title 36, Chapter 28.1 and this Chapter; or
2. Implement the policies and procedures or comply with the statements provided to the Department with the dispensary’s application.

E. If the Department denies a dispensary registration certificate application, the Department shall provide notice to the applicant that includes:
   1. The specific reason or reasons for the denial, and
   2. All other information required by A.R.S. § 41-1076.

F. If the Department revokes a dispensary registration certificate, the Department shall provide notice to the dispensary that includes:
   1. The specific reason or reasons for the revocation; and
   2. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

R9-17-323. Denial or Revocation of a Dispensary Agent’s Registry Identification Card

A. The Department shall deny a dispensary agent’s application for or renewal of the dispensary agent’s registry identification card if the dispensary agent:
   1. Does not meet the definition “nonprofit medical marijuana dispensary agent” in A.R.S. § 36-2801; or
   2. Previously had a registry identification card revoked for not complying with A.R.S. Title 36, Chapter 28.1 or this Chapter.

B. The Department may deny a dispensary agent’s application for or renewal of the dispensary agent’s registry identification card if the dispensary agent provides false or misleading information to the Department.

C. The Department shall revoke a dispensary agent’s registry identification card if the dispensary agent:
   1. Uses medical marijuana, if the dispensary agent does not have a qualifying patient registry identification card;
   2. Diverts marijuana to an entity other than:
      a. Another dispensary with a valid dispensary registration certificate issued by the Department,
      b. A laboratory with a valid laboratory registration certificate issued by the Department,
      c. A qualifying patient with a valid registry identification card issued by the Department,
      d. A designated caregiver with a valid registry identification card issued by the Department,
      e. A dispensary agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a dispensary, or
      f. A laboratory agent with a valid registry identification card issued by the Department accepting the marijuana on behalf of a laboratory; or
3. Has been convicted of an excluded felony offense.

D. The Department may revoke a dispensary agent’s registry identification card if the dispensary agent knowingly violates A.R.S. Title 36, Chapter 28.1 or this Chapter.

E. If the Department denies or revokes a dispensary agent’s registry identification card, the Department shall provide notice to the dispensary agent and the dispensary agent’s dispensary that includes:
   1. The specific reason or reasons for the denial or revocation; and
   2. The process for requesting a judicial review of the Department’s decision pursuant to A.R.S. Title 12, Chapter 7, Article 6.

R9-17-324. Dual Licensees

A. If a dispensary is a dual licensee, the dispensary shall:
   1. Provide marijuana and marijuana products, according to A.A.C. R9-18-309, to consumers, as defined in A.R.S. § 36-2850, at the same location as the dispensary dispenses medical marijuana and marijuana products to qualifying patients and designated caregivers;
   2. Notify the Department within five calendar days after beginning to operate on a for-profit basis, as allowed by A.R.S. § 36-2858(D)(2), and, if applicable, provide to the Department the documents required in R9-17-304(C)(2) for the new organizational or corporate structure; and
   3. Comply with the requirements in A.R.S. § 36-2858(D)(3).

B. If a dispensary is a dual licensee, the entity holding the valid dispensary registration certificate may:
   1. Request that the dispensary’s cultivation site, specified according to R9-17-305(A)(1)(e) or R9-17-307(A)(1), be transferred under the entity’s marijuana establishment license according to A.A.C. R9-18-303(E)(3);
   2. Request approval of a change in the location in subsection (A)(1) by complying with the requirements in both:
      a. R9-17-307(A), and
      b. A.A.C. R9-18-306; or
   3. Transfer or assign both the dispensary registration certificate and the marijuana establishment license to the same entity.

C. A dispensary that is a dual licensee may allow an individual without a dispensary agent registry identification card to be employed by or contracted with the dispensary and into areas of the dispensary or the dispensary’s cultivation site where marijuana is cultivated, processed, manufactured, or stored if:
1. The individual has a marijuana facility agent license, issued under 9 A.A.C. 18, Article 2, associated with the entity holding the dispensary’s dispensary registration certificate and marijuana establishment license; or

2. The individual:
   a. Is not at the dispensary or the dispensary’s cultivation site more than once per week; and
   b. When at the dispensary or the dispensary’s cultivation site, is supervised by a dispensary agent who has a valid registry identification card or an individual in subsection (C)(1).

D. A dispensary that is a dual licensee is exempt from the requirements in:

1. R9-17-310(A)(5), (12), and (13);
2. R9-17-313; and
3. R9-17-320(B)(4) and (5), but shall ensure that a dispensary agent or marijuana facility agent at the dispensary or the dispensary’s cultivation site:
   a. Reports to a principal officer or board member of the dispensary any health condition experienced by the dispensary agent or marijuana facility agent that may adversely affect the safety or quality of any medical marijuana or marijuana products with which the dispensary agent or marijuana facility agent may come into contact; and
   b. If the principal officer or board member determines that a dispensary agent or marijuana facility agent has a health condition that may adversely affect the safety or quality of the medical marijuana or marijuana products, is prohibited from direct contact with any medical marijuana, marijuana products, or equipment or materials for processing medical marijuana or marijuana products until the principal officer or board member determines that the dispensary agent’s or marijuana facility agent’s health condition will not adversely affect the medical marijuana or marijuana products.

E. A dual licensee:

1. If the dispensary has notified the Department according to subsection (A)(2) that the dispensary has begun operating on a for-profit basis and provided a valid marijuana establishment license number according to R9-17-308(1)(c), is exempt from the requirements in R9-17-308(3); and
2. If the dispensary is still operating on a not-for-profit basis and provided a valid marijuana establishment license number according to R9-17-308(1)(c), may submit to the Department when renewing the dispensary’s dispensary registration certificate an attestation, in a Department-provided format, that the dispensary is operating on a not-for-profit basis in lieu of submitting the copy of an annual financial statement required in R9-17-308(3)(a) and the report of an audit required in R9-17-308(3)(b).
F. If the Department identifies an instance of noncompliance with a requirement of both this Chapter and 9 A.A.C. 18 during an inspection of a dual licensee, the Department shall note the instance of noncompliance on a notice of deficiencies associated with the dual licensee’s marijuana establishment license under 9 A.A.C. 18, rather than on both the notice of deficiencies for the dispensary registration certificate and the notice of deficiencies for the marijuana establishment license.
Statutory Authority for Rules in 9 A.A.C. 17

36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.

2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.

3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.

4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.

5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.

6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.

7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.

8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.

9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.

12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.

13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and
local health agencies involved with water quality shall provide to the department any assistance requested by
the director to ensure that this paragraph is effectuated.

14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title,
chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the
federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).

15. Recruit and train personnel for state, local and district health departments.

16. Conduct continuing evaluations of state, local and district public health programs, study and appraise
state health problems and develop broad plans for use by the department and for recommendation to other
agencies, professions and local health departments for the best solution of these problems.

17. License and regulate health care institutions according to chapter 4 of this title.

18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to
meet wartime or other disasters.

20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
(a) Screening in early pregnancy for detecting high-risk conditions.
(b) Comprehensive prenatal health care.
(c) Maternity, delivery and postpartum care.
(d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when
medically indicated.
(e) Perinatal education oriented toward professionals and consumers, focusing on early detection and
adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The
department shall issue a license to an accredited facility for a period of the accreditation, except that no
licensing period shall be longer than three years. The department is authorized to conduct an inspection of an
accredited facility to ensure that the facility meets health and safety licensure standards. The results of the
accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the
department of health services. For the purposes of this paragraph, "accredited" means accredited by a
nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal
government, and from private donors, trusts, foundations or eleemosynary corporations or organizations
grants or donations for or in aid of the construction or maintenance of any program, project, research or
facility authorized by this title, or in aid of the construction or maintenance of any program, project, research or
facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility
authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an
agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations
or organizations, to carry out such purposes. All monies made available under this section are special project
grants. The department may also expend these monies to further applicable scientific research within this
state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The
department shall not set a fee at more than the department's cost of providing the service for which the fee is
charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant
operations and organizations that primarily assist in the management of end-stage renal disease and related
problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and
transportation to and from treatment facilities. The contracts may provide for department payment of
administrative costs it specifically authorizes.
36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:
1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. If in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for not longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.
(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fundraising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

(j) Spirituous liquor produced on the premises licensed by the department of liquor licenses and control. This exemption includes both of the following:

(i) The area in which production and manufacturing of spirituous liquor occurs, as defined in an active basic permit on file with the United States alcohol and tobacco tax and trade bureau.

(ii) The area licensed by the department of liquor licenses and control as a microbrewery, farm winery or craft distiller that is open to the public and serves spirituous liquor and commercially prepackaged food, crackers or pretzels for consumption on the premises. A producer of spirituous liquor may not provide, allow or expose for common use any cup, glass or other receptacle used for drinking purposes. For the purposes of this item, "common use" means the use of a drinking receptacle for drinking purposes by or for more than one person without the receptacle being thoroughly cleansed and sanitized between consecutive uses by methods prescribed by or acceptable to the department.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules...
shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for preserving or storing food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparing food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".
J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (j) of this section, spirituous liquor and commercially prepackaged food, crackers or pretzels that meet the requirements of subsection I, paragraph 4, subdivision (j) of this section are exempt from the rules prescribed in subsection I of this section.

R. For the purposes of this section:

1. "Cottage food product":

(a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.

(b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

36-2803. Rulemaking; notice; testing of marijuana and marijuana products; fees

A. The department shall adopt rules:
1. Governing the manner in which the department considers petitions from the public to add debilitating medical conditions or treatments to the list of debilitating medical conditions set forth in section 36-2801, paragraph 3, including public notice of, and an opportunity to comment in a public hearing on, petitions.

2. Establishing the form and content of registration and renewal applications submitted under this chapter.

3. Governing the manner in which the department considers applications for and renewals of registry identification cards.

4. Governing nonprofit medical marijuana dispensaries to protect against diversion and theft without imposing an undue burden on nonprofit medical marijuana dispensaries or compromising the confidentiality of cardholders, including:
   (a) The manner in which the department considers applications for and renewals of registration certificates.
   (b) Minimum oversight requirements for nonprofit medical marijuana dispensaries.
   (c) Minimum recordkeeping requirements for nonprofit medical marijuana dispensaries.
   (d) Minimum security requirements for nonprofit medical marijuana dispensaries, including requirements to protect each registered nonprofit medical marijuana dispensary location by a fully operational security alarm system.
   (e) Procedures for suspending or revoking the registration certificate of nonprofit medical marijuana dispensaries that violate this chapter or the rules adopted pursuant to this section.

5. Establishing application and renewal fees for registry identification cards, nonprofit medical marijuana dispensary registration certificates and independent third-party laboratory certificates, according to the following:
   (a) The total amount of all fees shall generate revenues that are sufficient to implement and administer this chapter, except that fee revenue may be offset or supplemented by private donations.
   (b) Nonprofit medical marijuana dispensary application fees may not exceed $5,000.
   (c) Nonprofit medical marijuana dispensary renewal fees may not exceed $1,000.
   (d) The total amount of revenue generated from nonprofit medical marijuana dispensary application and renewal fees, registry identification card fees for nonprofit medical marijuana dispensary agents and independent third-party laboratory agents and application and renewal fees for independent third-party laboratories shall be sufficient to implement and administer this chapter, including the verification system, except that the fee revenue may be offset or supplemented by private donations.
   (e) The department may establish a sliding scale of patient application and renewal fees that are based on a qualifying patient's household income and that are reasonable and related to the actual costs of processing applications and renewals.
   (f) The department may consider private donations under section 36-2817 to reduce application and renewal fees.

B. The department of health services shall adopt rules that require each nonprofit medical marijuana dispensary to display in a conspicuous location a sign that warns pregnant women about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report. The rules shall include the specific warning language that must be included on the sign. The cost and display of the sign required by rule shall be borne by the nonprofit medical marijuana dispensary. The rules shall also require each certifying physician to attest that the physician has provided information to each qualifying female patient that warns about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report.

C. The department is authorized to adopt the rules set forth in subsections A and B of this section and shall adopt those rules pursuant to title 41, chapter 6.
D. The department of health services shall post prominently on its public website a warning about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report.

E. Before selling or dispensing marijuana or marijuana products to registered qualified patients or registered designated caregivers, nonprofit medical marijuana dispensaries shall test marijuana and marijuana products for medical use to determine unsafe levels of contamination, including unsafe levels of microbial contamination, heavy metals, pesticides, fungicides, growth regulators and residual solvents and confirm the potency of the marijuana to be dispensed. The dried flowers of the marijuana plant are not required to be tested for residual solvents. If a nonprofit medical marijuana dispensary's test results for heavy metals comply with the prescribed requirements for a period of six consecutive months, heavy metal testing for that dispensary's marijuana and marijuana products is required only on a quarterly basis.

F. Nonprofit medical marijuana dispensaries shall:

1. Provide test results to a registered qualifying patient or designated caregiver immediately on request.

2. Display in a conspicuous location a sign that notifies patients of their right to receive the certified independent third-party laboratory test results for marijuana and marijuana products for medical use.

G. The department shall adopt rules to certify and regulate independent third-party laboratories that analyze marijuana cultivated for medical use. The department shall establish certification fees for laboratories pursuant to subsection A of this section. In order to be certified as an independent third-party laboratory that is allowed to test marijuana and marijuana products for medical use pursuant to this chapter, an independent third-party laboratory:

1. Must meet requirements established by the department, including reporting and health and safety requirements.

2. May not have any direct or indirect familial or financial relationship with or interest in a nonprofit medical marijuana dispensary or related medical marijuana business entity or management company, or any direct or indirect familial or financial relationship with a designated caregiver for whom the laboratory is testing marijuana and marijuana products for medical use in this state.

3. Must have a quality assurance program and standards.

4. Must have an adequate chain of custody and sample requirement policies.

5. Must have an adequate records retention process to preserve records.

6. Must establish procedures to ensure that results are accurate, precise and scientifically valid before reporting the results.

7. Must be accredited by a national or international accreditation association or other similar accrediting entity, as determined by the department.

8. Must establish policies and procedures for disposal and reverse distribution of samples that are collected by the laboratory.

H. Through December 31, 2022, the department may conduct proficiency testing and remediate problems with independent third-party laboratories that are certified and regulated pursuant to this chapter and marijuana testing facilities that are licensed and regulated pursuant to chapter 28.2 of this title.

I. Beginning January 1, 2023, the department shall conduct proficiency testing and remediate problems with independent third-party laboratories that are certified and regulated pursuant to this chapter and marijuana testing facilities that are licensed and regulated pursuant to chapter 28.2 of this title. The department may contract for proficiency testing with laboratories that have a national or international accreditation.

J. For the purposes of subsections H and I of this section, remediation may include assessing civil penalties and suspending or revoking a laboratory’s certification or a marijuana testing facility’s license.

K. The department shall adopt rules that prescribe reasonable time frames for testing marijuana and marijuana products.
36-2803.01. New dispensary registration certificates; issuance; priority; requirements; definition

A. Beginning on April 1, 2020, the department shall issue all new nonprofit medical marijuana dispensary registration certificates in the following order of priority based on the dispensary's geographic area as described in the registration certificate application:

1. The geographic area had a registered nonprofit medical marijuana dispensary move from the geographic area and the geographic area is at least twenty-five miles from another dispensary that has been issued a dispensary registration certificate.

2. The geographic area is at least twenty-five miles from another dispensary that has been issued a dispensary registration certificate.

3. According to rule, if there are no dispensary registration certificate applications as described in paragraph 1 or 2 of this subsection.

B. If the department receives multiple applications as described in subsection A, paragraph 1 of this section from previously approved nonprofit medical marijuana dispensary locations, the department shall approve the certificate for the application that serves the most qualifying patients within five miles of the proposed dispensary location. If the department receives multiple applications as described in subsection A, paragraph 2 of this section or if there are no applications from previously approved dispensary locations, the department may issue the registration certificate by random drawing.

C. A nonprofit medical marijuana dispensary that receives a registration certificate pursuant to subsection A, paragraph 1 or 2 of this section on or after April 1, 2020 must open the dispensary at the approved location within eighteen months after the application is approved or the registration certificate becomes invalid.

D. A nonprofit medical marijuana dispensary that is issued a registration certificate pursuant to subsection A, paragraph 1 or 2 of this section may relocate only as follows:

1. If the dispensary is located within a city or town, only within that city or town.

2. If the dispensary is located within an unincorporated area, only within the unincorporated area of the county where the dispensary is located but not within twenty-five miles from another dispensary that has been issued a dispensary registration certificate.

E. For the purposes of this section, "geographic area" means a city, town or unincorporated area of a county.

36-2804. Registration and certification of nonprofit medical marijuana dispensaries

A. Nonprofit medical marijuana dispensaries shall register with the department.

B. Not later than ninety days after receiving an application for a nonprofit medical marijuana dispensary, the department shall register the nonprofit medical marijuana dispensary and issue a registration certificate and a random 20-digit alphanumeric identification number if:

1. The prospective nonprofit medical marijuana dispensary has submitted the following:

   (a) The application fee.

   (b) An application, including:

      (i) The legal name of the nonprofit medical marijuana dispensary.

      (ii) The physical address of the nonprofit medical marijuana dispensary and the physical address of one additional location, if any, where marijuana will be cultivated, neither of which may be within five hundred feet of a public or private school existing before the date of the nonprofit medical marijuana dispensary application.

      (iii) The name, address and date of birth of each principal officer and board member of the nonprofit medical marijuana dispensary.

      (iv) The name, address and date of birth of each nonprofit medical marijuana dispensary agent.

   (c) Operating procedures consistent with department rules for oversight of the nonprofit medical marijuana dispensary, including procedures to ensure accurate record-keeping and adequate security measures.
(d) If the city, town or county in which the nonprofit medical marijuana dispensary would be located has enacted zoning restrictions, a sworn statement certifying that the registered nonprofit medical marijuana dispensary is in compliance with the restrictions.

2. None of the principal officers or board members has been convicted of an excluded felony offense.

3. None of the principal officers or board members has served as a principal officer or board member for a registered nonprofit medical marijuana dispensary that has had its registration certificate revoked.

4. None of the principal officers or board members is under twenty-one years of age.

C. The department may not issue more than one nonprofit medical marijuana dispensary registration certificate for every ten pharmacies that have registered under section 32-1929, have obtained a pharmacy permit from the Arizona board of pharmacy and operate within the state except that the department may issue nonprofit medical marijuana dispensary registration certificates in excess of this limit if necessary to ensure that the department issues at least one nonprofit medical marijuana dispensary registration certificate in each county in which an application has been approved.

D. The department may conduct a criminal records check in order to carry out this section.

36-2804.01. Registration; nonprofit medical marijuana dispensary agents; independent third-party laboratory agents; notices

A. A nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent shall be registered with the department before volunteering or working at a nonprofit medical marijuana dispensary or an independent third-party laboratory.

B. A nonprofit medical marijuana dispensary or a certified independent third-party laboratory may apply to the department for a registry identification card for a nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent by submitting:

1. The name, address and date of birth of the prospective nonprofit medical marijuana dispensary agent or independent third-party laboratory agent.

2. A nonprofit medical marijuana dispensary agent or independent third-party laboratory agent application.

3. A statement signed by either:

   (a) The prospective nonprofit medical marijuana dispensary agent pledging not to divert marijuana to anyone who is not allowed to possess marijuana pursuant to this chapter.

   (b) The prospective independent third-party laboratory agent acknowledging that registered independent third-party laboratory agents are prohibited from diverting marijuana pursuant to this chapter.

4. The application fee.

C. A registered nonprofit medical marijuana dispensary or certified independent third-party laboratory shall notify the department within ten days after a nonprofit medical marijuana dispensary agent or independent third-party laboratory agent ceases to be employed by or volunteer at the registered nonprofit medical marijuana dispensary or certified independent third-party laboratory.

D. A person who has been convicted of an excluded felony offense may not be a nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent.

E. The department may conduct a criminal records check in order to carry out this section.

36-2806. Registered nonprofit medical marijuana dispensaries; requirements; rules; inspections; testing

A. A registered nonprofit medical marijuana dispensary shall be operated on a not-for-profit basis. The bylaws of a registered nonprofit medical marijuana dispensary shall contain such provisions relative to the disposition of revenues and receipts to establish and maintain its nonprofit character. A registered nonprofit medical marijuana dispensary need not be recognized as tax-exempt by the internal revenue service and is not required to incorporate pursuant to title 10, chapter 19, article 1.
B. The operating documents of a registered nonprofit medical marijuana dispensary shall include procedures for the oversight of the registered nonprofit medical marijuana dispensary and procedures to ensure accurate recordkeeping.

C. A registered nonprofit medical marijuana dispensary shall have a single secure entrance and shall implement appropriate security measures to deter and prevent the theft of marijuana and unauthorized entrance into areas containing marijuana.

D. A registered nonprofit medical marijuana dispensary is prohibited from acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the registered qualifying patients’ designated caregivers or an independent third-party laboratory agent or a certified independent third-party laboratory for the purposes prescribed in this chapter and department rule.

E. All cultivation of marijuana must take place in an enclosed, locked facility, at a physical address provided to the department during the registration process, that can be accessed only by registered nonprofit medical marijuana dispensary agents associated in the registry with the nonprofit medical marijuana dispensary.

F. A registered nonprofit medical marijuana dispensary may acquire usable marijuana or marijuana plants from a registered qualifying patient or a registered designated caregiver only if the registered qualifying patient or registered designated caregiver receives no compensation for the marijuana.

G. A nonprofit medical marijuana dispensary shall not allow any person to consume marijuana on the property of the nonprofit medical marijuana dispensary.

H. Registered nonprofit medical marijuana dispensaries are subject to reasonable inspection by the department. The department shall give reasonable notice of an inspection under this subsection.

I. Beginning November 1, 2020, registered nonprofit medical marijuana dispensaries are subject to product testing by certified independent third-party laboratories pursuant to this chapter and rules adopted pursuant to this chapter.

J. Notwithstanding title 13, chapter 34, an employee of the department or an independent third-party laboratory agent may not be charged with or prosecuted for possession of marijuana that is cultivated for medical use as required by this chapter and the rules adopted pursuant to this chapter.

36-2819. Fingerprinting requirements

Each person applying as a designated caregiver, a principal officer, agent or employee of a nonprofit medical marijuana dispensary, a medical marijuana dispensary agent or an independent third-party laboratory agent shall submit a full set of fingerprints to the department for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation without disclosing that the records check is related to the medical marijuana act and acts permitted by it. The department shall destroy each set of fingerprints after the criminal records check is completed.
Conference Engrossed
medical marijuana; testing

State of Arizona
House of Representatives
Fifty-fifth Legislature
First Regular Session
2021

CHAPTER 439

HOUSE BILL 2605

AN ACT

AMENDING SECTIONS 36-2803, 36-2804.01, 36-2816, 36-2819, 36-2821, 36-2854
AND 41-1758.07, ARIZONA REVISED STATUTES; RELATING TO MEDICAL MARIJUANA.

(TEXT OF BILL BEGINS ON NEXT PAGE)
Be it enacted by the Legislature of the State of Arizona:

Section 1. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2803, Arizona Revised Statutes, is amended to read:

36-2803. Rulemaking; notice; testing of marijuana and marijuana products; fees

A. The department shall adopt rules:

1. Governing the manner in which the department considers petitions from the public to add debilitating medical conditions or treatments to the list of debilitating medical conditions set forth in section 36-2801, paragraph 3, including public notice of, and an opportunity to comment in a public hearing on, petitions.

2. Establishing the form and content of registration and renewal applications submitted under this chapter.

3. Governing the manner in which the department considers applications for and renewals of registry identification cards.

4. Governing nonprofit medical marijuana dispensaries to protect against diversion and theft without imposing an undue burden on nonprofit medical marijuana dispensaries or compromising the confidentiality of cardholders, including:

   (a) The manner in which the department considers applications for and renewals of registration certificates.

   (b) Minimum oversight requirements for nonprofit medical marijuana dispensaries.

   (c) Minimum recordkeeping requirements for nonprofit medical marijuana dispensaries.

   (d) Minimum security requirements for nonprofit medical marijuana dispensaries, including requirements to protect each registered nonprofit medical marijuana dispensary location by a fully operational security alarm system.

   (e) Procedures for suspending or revoking the registration certificate of nonprofit medical marijuana dispensaries that violate this chapter or the rules adopted pursuant to this section.

5. Establishing application and renewal fees for registry identification cards, nonprofit medical marijuana dispensary registration certificates and independent third-party laboratory certificates, according to the following:

   (a) The total amount of all fees shall generate revenues that are sufficient to implement and administer this chapter, except that fee revenue may be offset or supplemented by private donations.

   (b) Nonprofit medical marijuana dispensary application fees may not exceed $5,000.

   (c) Nonprofit medical marijuana dispensary renewal fees may not exceed $1,000.
(d) The total amount of revenue generated from nonprofit medical marijuana dispensary application and renewal fees, registry identification card fees for nonprofit medical marijuana dispensary agents and independent third-party laboratory agents and application and renewal fees for independent third-party laboratories shall be sufficient to implement and administer this chapter, including the verification system, except that the fee revenue may be offset or supplemented by private donations.

(e) The department may establish a sliding scale of patient application and renewal fees based on a qualifying patient's household income.

(f) The department may consider private donations under section 36-2817 to reduce application and renewal fees.

B. The department of health services shall adopt rules that require each nonprofit medical marijuana dispensary to display in a conspicuous location a sign that warns pregnant women about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report. The rules shall include the specific warning language that must be included on the sign. The cost and display of the sign required by rule shall be borne by the nonprofit medical marijuana dispensary. The rules shall also require each certifying physician to attest that the physician has provided information to each qualifying female patient that warns about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report.

C. The department is authorized to adopt the rules set forth in subsections A and B of this section and shall adopt those rules pursuant to title 41, chapter 6.

D. The department of health services shall post prominently on its public website a warning about the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding and the risk of being reported to the department of child safety during pregnancy or at the birth of the child by persons who are required to report.

E. Beginning November 1, 2020, Before selling or dispensing marijuana or marijuana products to registered qualified patients or registered designated caregivers, nonprofit medical marijuana dispensaries shall test marijuana and marijuana products for medical use to determine unsafe levels of contamination, including unsafe levels of microbial contamination, heavy metals, pesticides, herbicides, fungicides, growth regulators and residual solvents and confirm the potency of the marijuana to be dispensed. THE DRIED FLOWERS OF THE MARIJUANA PLANT ARE NOT
REQUIRED TO BE TESTED FOR RESIDUAL SOLVENTS. IF A NONPROFIT MEDICAL MARIJUANA DISPENSARY’S TEST RESULTS FOR HEAVY METALS COMPLY WITH THE PRESCRIBED REQUIREMENTS FOR A PERIOD OF SIX CONSECUTIVE MONTHS, HEAVY METAL TESTING FOR THAT DISPENSARY’S MARIJUANA AND MARIJUANA PRODUCTS IS REQUIRED ONLY ON A QUARTERLY BASIS.

F. Beginning November 1, 2020, Nonprofit medical marijuana dispensaries shall:

1. Provide test results to a registered qualifying patient or designated caregiver immediately on request.
2. Display in a conspicuous location a sign that notifies patients of their right to receive the certified independent third-party laboratory test results for marijuana and marijuana products for medical use.

G. The department shall adopt rules to certify and regulate independent third-party laboratories that analyze marijuana cultivated for medical use. The department shall establish certification fees for laboratories pursuant to subsection A of this section. In order to be certified as an independent third-party laboratory that is allowed to test marijuana and marijuana products for medical use pursuant to this chapter, an independent third-party laboratory:

1. Must meet requirements established by the department, including reporting and health and safety requirements.
2. May not have any direct or indirect familial or financial relationship with or interest in a nonprofit medical marijuana dispensary or related medical marijuana business entity or management company, or any direct or indirect familial or financial relationship with a designated caregiver for whom the laboratory is testing marijuana and marijuana products for medical use in this state.
3. Must have a quality assurance program and standards.
4. Must have an adequate chain of custody and sample requirement policies.
5. Must have an adequate records retention process to preserve records.
6. Must establish procedures to ensure that results are accurate, precise and scientifically valid before reporting the results.
7. Must be accredited by a national or international accreditation association or other similar accrediting entity, as determined by the department.
8. Must establish policies and procedures for disposal and reverse distribution of samples that are collected by the laboratory.

H. The department may conduct proficiency testing and remediate problems with independent third-party laboratories that are certified and regulated pursuant to this chapter. Remediation may include assessing civil penalties and suspending or revoking a laboratory's certification.

I. THE DEPARTMENT SHALL ADOPT RULES THAT PRESCRIBE REASONABLE TIME FRAMES FOR TESTING MARIJUANA AND MARIJUANA PRODUCTS.
Sec. 2. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2804.01, Arizona Revised Statutes, is amended to read:

36-2804.01. Registration; nonprofit medical marijuana dispensary agents; independent third-party laboratory agents; requirements

A. A nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent shall be registered with the department before volunteering or working at a nonprofit medical marijuana dispensary or \textit{A CERTIFIED} independent third-party laboratory.

B. A nonprofit medical marijuana dispensary or a certified independent third-party laboratory may apply to the department for a registry identification card for a nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent by submitting:

1. The name, address and date of birth of the prospective nonprofit medical marijuana dispensary agent or independent third-party laboratory agent.

2. A nonprofit medical marijuana dispensary agent or independent third-party laboratory agent application.

3. A statement signed by either:
   (a) The prospective nonprofit medical marijuana dispensary agent pledging not to divert marijuana to anyone who is not allowed to possess marijuana pursuant to this chapter.
   (b) The prospective independent third-party laboratory agent acknowledging that registered independent third-party laboratory agents are prohibited from diverting marijuana pursuant to this chapter.

4. The application fee.

C. A registered nonprofit medical marijuana dispensary or certified independent third-party laboratory shall notify the department within ten days after a nonprofit medical marijuana dispensary agent or independent third-party laboratory agent ceases to be employed by or volunteer at the registered nonprofit medical marijuana dispensary or certified independent third-party laboratory.

D. A person who has been convicted of an excluded felony offense may not be a nonprofit medical marijuana dispensary agent or an independent third-party laboratory agent. NOTWITHSTANDING ANY OTHER PROVISION OF THIS CHAPTER, IF A PROSPECTIVE NONPROFIT MEDICAL MARIJUANA DISPENSARY AGENT OR INDEPENDENT THIRD-PARTY LABORATORY AGENT HOLDS A CURRENT LEVEL I FINGERPRINT CLEARANCE CARD, THE PERSON IS DEEMED TO NOT HAVE BEEN CONVICTED OF AN EXCLUDED FELONY OFFENSE.

E. The department may conduct a criminal records check in order to carry out this section.

F. NOTWITHSTANDING ANY OTHER PROVISION OF THIS CHAPTER, IF A MARIJUANA FACILITY AGENT AS DEFINED IN SECTION 36-2850 IS REGISTERED WITH THE DEPARTMENT PURSUANT TO SECTION 36-2855, THE PERSON MAY ACT IN THE
CAPACITY OF A NONPROFIT MEDICAL MARIJUANA DISPENSARY AGENT WITHOUT REGISTERING PURSUANT TO THIS CHAPTER.

Sec. 3. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2816, Arizona Revised Statutes, is amended to read:

36-2816. Violations; classification; civil penalties
A. A registered qualifying patient may not directly, or through the patient's designated caregiver, obtain more than two and one-half ounces of marijuana from registered nonprofit medical marijuana dispensaries in any fourteen-day period.
B. A registered nonprofit medical marijuana dispensary or agent may not dispense, deliver or otherwise transfer marijuana to a person other than:
   1. Another registered nonprofit medical marijuana dispensary.
   2. A registered qualifying patient.
   3. A registered qualifying patient's registered designated caregiver.
   4. A certified independent third-party laboratory or an independent third-party laboratory agent for purposes prescribed in sections 36-2803 and 36-2806 and department rule.
C. A registered nonprofit medical marijuana dispensary may not acquire usable marijuana or mature marijuana plants from any person other than another registered nonprofit medical marijuana dispensary, a registered qualifying patient or a registered designated caregiver. A knowing violation of this subsection is a class 2 felony.
D. It is a class 1 misdemeanor for any person, including an employee or official of the department or another state agency or local government, to breach the confidentiality of information obtained pursuant to this chapter.
E. Making false statements to a law enforcement official about any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution is subject to a civil penalty of not more than $500, which shall be in addition to any other penalties that may apply for making a false statement or for the use of marijuana other than use undertaken pursuant to this chapter.
F. Subject to title 41, chapter 6, article 10, the director may deny, suspend or revoke, in whole or in part, any registration issued under this chapter if the registered party or an officer, agent or employee of the registered party is not in substantial compliance with the provisions of this chapter or any rule adopted pursuant to this chapter or if the nature or number of violations revealed by any type of inspection or investigation constitutes a threat, or direct risk, to the life, health or safety of a qualifying patient or the public.
G. In addition to any other penalties authorized by this chapter, the director may assess a civil penalty for violations of this chapter or any rule adopted pursuant to this chapter in an amount not to exceed $1,000 for each violation. Each day a violation occurs constitutes a separate violation. The maximum amount of any assessment is $5,000 for any thirty-day period.

H. The director shall issue a notice of assessment that includes the proposed amount of the assessment. In determining the amount of a civil penalty assessed against a person under subsection G of this section, the department shall consider all of the following:
   1. Repeated violations of this chapter or the rules adopted pursuant to this chapter.
   2. Patterns of noncompliance.
   3. The types of violations.
   4. The severity of the violations.
   5. The potential for and occurrences of actual harm.
   6. Threats to health and safety.
   7. The number of violations.
   8. The number of persons affected by the violations.
   9. The length of time the violations have been occurring.

Sec. 4. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2819, Arizona Revised Statutes, is amended to read:

36-2819. Fingerprinting requirements

Each person applying as a designated caregiver, a principal officer, agent or employee of a nonprofit medical marijuana dispensary, a NONPROFIT medical marijuana dispensary agent or an independent third-party laboratory agent MAY SUBMIT A CURRENT LEVEL I FINGERPRINT CLEARANCE CARD ISSUED PURSUANT TO SECTION 41-1758.07 OR shall submit a full set of fingerprints to the department for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation without disclosing that the records check is related to the medical marijuana act and acts ALLOWED by it. The department shall destroy each set of fingerprints after the criminal records check is completed.

Sec. 5. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2821, Arizona Revised Statutes, is amended to read:

36-2821. Medical marijuana testing advisory council; membership; duties; report; council termination; definitions

A. The director shall establish a medical marijuana testing advisory council to assist and make recommendations to the director regarding administering and implementing this chapter. The director or
the director's designee shall serve as the chairperson of the advisory council and shall appoint the following additional members to the council:

1. The president or executive director of a statewide nonprofit association representing the marijuana dispensaries, or the person's designee.
2. The president or executive director of a statewide nonprofit cannabis testing association, or the person's designee.
3. The president or executive director of a medical marijuana trade association that does not primarily consist of dispensaries or cannabis laboratory testing facility owners, or the person's designee.
4. A representative of a nonprofit medical marijuana dispensary who is employed by the dispensary to cultivate medical marijuana and who has at least three years of medical marijuana cultivation experience.
5. A representative of an Arizona-based nonprofit medical marijuana dispensary that produces medical marijuana concentrates and that has been regularly sending products for testing who has at least three years of medical marijuana extraction experience.
6. A representative of an Arizona-based nonprofit medical marijuana dispensary that is primarily focused on producing medical marijuana edibles who has at least three years of medical marijuana edible production experience.
7. An owner of an Arizona-based cannabis testing laboratory.
8. A laboratory scientist who holds a doctorate or a bachelor of science degree and who has at least three years of experience in cannabis laboratory testing.
10. A registered designated caregiver.
11. A representative of the department of public safety.
12. A licensed health care provider who specializes in treating substance use disorders and who has at least five years of experience.
13. Any other members deemed necessary by the director.

14. A representative of a laboratory that conducts proficiency testing for laboratories in this state.

B. The medical marijuana testing advisory council shall make recommendations and consult with the director regarding:

1. Establishing a required testing program.
2. Testing and potency standards for medical marijuana.
3. Procedural requirements for collecting, storing and testing samples of medical marijuana.
4. Reporting results to patients and the department.
5. Remediation and disposal requirements for medical marijuana that fails to meet testing standards.
6. Additional items as necessary.


1. AN ASSESSMENT AS TO WHETHER AN ANALYTE SHOULD BE REMOVED FROM THE REQUIRED STATUTORY TESTING PANEL.

2. THE NUMBER OF STATEMENTS OF DEFICIENCIES RELATING TO TESTING THAT WERE ISSUED TO EACH NONPROFIT MEDICAL MARIJUANA DISPENSARY, THIRD-PARTY INDEPENDENT LABORATORY, MARIJUANA ESTABLISHMENT AND MARIJUANA TESTING FACILITY IN THE PRECEDING YEAR, THE REMEDIATION EFFORTS MADE TO ADDRESS EACH DEFICIENCY AND THE RESOLUTION OF EACH STATEMENT OF DEFICIENCY. THE INFORMATION MAY NOT DISCLOSE ANY IDENTIFYING INFORMATION BUT SHALL DELINEATE THE INFORMATION BY ENTITY.

3. ANY OTHER RECOMMENDATIONS ON IMPROVING THE TESTING PROGRAMS.

D. Members of the advisory council are not eligible to receive compensation but are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

E. The council established by PURSUANT TO this section ends on July 1, 2027 pursuant to section 41-3103.

F. FOR THE PURPOSES OF THIS SECTION, "MARIJUANA ESTABLISHMENT" AND "MARIJUANA TESTING FACILITY" HAVE THE SAME MEANINGS PRESCRIBED IN SECTION 36-2850.

Sec. 6. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2854, Arizona Revised Statutes, is amended to read:

36-2854. Rules; licensing; early applicants; fees; civil penalty; legal counsel

A. The department shall adopt rules to implement and enforce this chapter and regulate marijuana, marijuana products, marijuana establishments and marijuana testing facilities. Those rules shall include requirements for:

1. Licensing marijuana establishments and marijuana testing facilities, including conducting investigations and background checks to determine eligibility for licensing for marijuana establishment and marijuana testing facility applicants, except that:

(a) An application for a marijuana establishment license or marijuana testing facility license may not require the disclosure of the
identity of any person who is entitled to a share of less than ten percent of the profits of an applicant that is a publicly traded corporation.

(b) The department may not issue more than one marijuana establishment license for every ten pharmacies that have registered under section 32-1929, that have obtained a pharmacy permit from the Arizona board of pharmacy and that operate within this state.

(c) Notwithstanding subdivision (b) of this paragraph, the department may issue a marijuana establishment license to not more than two marijuana establishments per county that contains no registered nonprofit medical marijuana dispensaries, or one marijuana establishment license per county that contains one registered nonprofit medical marijuana dispensary. Any license issued pursuant to this subdivision shall be for a fixed county and may not be relocated outside of that county.

(d) The department shall accept applications for marijuana establishment licenses from early applicants beginning January 19, 2021 through March 9, 2021. Not later than sixty days after receiving an application pursuant to this subdivision, the department shall issue a marijuana establishment license to each qualified early applicant. If the department has not adopted final rules pursuant to this section at the time marijuana establishment licenses are issued pursuant to this subdivision, licensees shall comply with the rules adopted by the department to implement chapter 28.1 of this title except those that are inconsistent with this chapter.

(e) After issuing marijuana establishment licenses to qualified early applicants, the department shall issue marijuana establishment licenses available under subdivisions (b) and (c) of this paragraph by random selection and according to rules adopted pursuant to this section. At least sixty days prior to any random selection, the department shall prominently publicize the random selection on its website and through other means of general distribution intended to reach as many interested parties as possible and shall provide notice through an email notification system to which interested parties can subscribe.

(f) Notwithstanding subdivisions (b) and (c) of this paragraph, and not later than six months after the department adopts final rules to implement a social equity ownership program pursuant to paragraph 9 of this subsection, the department shall issue twenty-six additional marijuana establishment licenses to entities that are qualified pursuant to the social equity ownership program.

(g) Licenses issued by the department to marijuana establishments and marijuana testing facilities shall be valid for a period of two years.

2. Licensing fees and renewal fees for marijuana establishments and marijuana testing facilities in amounts that are reasonable and related to the actual cost of processing applications for licenses and renewals and
that do not exceed five times the fees prescribed by the department to
register or renew a nonprofit medical marijuana dispensary.

3. The security of marijuana establishments and marijuana testing
facilities.

4. Marijuana establishments to safely cultivate, process and
manufacture marijuana and marijuana products.

5. Tracking, testing, labeling and packaging marijuana and
marijuana products, including requirements that marijuana and marijuana
products be:
   (a) Sold to consumers in clearly and conspicuously labeled
containers that contain accurate warnings regarding the use of marijuana
or marijuana products.
   (b) Placed in child-resistant packaging on exit from a marijuana
establishment.

6. Forms of government-issued identification that are acceptable by
a marijuana establishment verifying a consumer's age and procedures
related to verifying a consumer's age consistent with section 4-241.
Until the department adopts final rules related to verifying a consumer's
age, marijuana establishments shall comply with the proof of legal age
requirements prescribed in section 4-241.

7. The potency of edible marijuana products that may be sold to
consumers by marijuana establishments at reasonable levels upon ON
consideration of industry standards, except that the rules:
   (a) Shall limit the strength of edible marijuana products to NOT
more than ten milligrams of tetrahydrocannabinol per serving or one
hundred milligrams of tetrahydrocannabinol per package.
   (b) Shall require that if a marijuana product contains more than
one serving, it must be delineated or scored into standard serving sizes
and homogenized to ensure uniform disbursement throughout the marijuana
product.

8. Ensuring the health, safety and training of employees of
marijuana establishments and marijuana testing facilities.

9. The creation and implementation of a social equity ownership
program to promote the ownership and operation of marijuana establishments
and marijuana testing facilities by individuals from communities
disproportionately impacted by the enforcement of previous marijuana laws.

10. PROHIBITING A MARIJUANA TESTING FACILITY FROM HAVING ANY DIRECT
OR INDIRECT FAMILIAL RELATIONSHIP WITH OR FINANCIAL OWNERSHIP INTEREST IN
A MARIJUANA ESTABLISHMENT OR RELATED MARIJUANA BUSINESS ENTITY OR
MANAGEMENT COMPANY. THE RULES SHALL INCLUDE PROHIBITING A MARIJUANA
ESTABLISHMENT FROM HAVING ANY DIRECT OR INDIRECT FAMILIAL RELATIONSHIP
WITH OR FINANCIAL OWNERSHIP INTEREST IN A MARIJUANA TESTING FACILITY OR
RELATED MARIJUANA BUSINESS ENTITY OR MANAGEMENT COMPANY.
B. The department may:

1. Subject to title 41, chapter 6, article 10, deny any application submitted or deny, suspend or revoke, in whole or in part, any registration or license issued under this chapter if the registered or licensed party or an officer, agent or employee of the registered or licensed party does any of the following:
   (a) Violates this chapter or any rule adopted pursuant to this chapter.
   (b) Has been, is or may continue to be in substantial violation of the requirements for licensing or registration and, as a result, the health or safety of the general public is in immediate danger.

2. Subject to title 41, chapter 6, article 10, and unless another penalty is provided elsewhere in this chapter, assess a civil penalty against a person that violates this chapter or any rule adopted pursuant to this chapter in an amount not to exceed $1,000 $2,000 for each violation. Each day a violation occurs constitutes a separate violation. The maximum amount of any assessment is $25,000 for any thirty-day period. In determining the amount of a civil penalty assessed against a person, the department shall consider all of the factors set forth in section 36-2816, subsection H. All civil penalties collected by the department pursuant to this paragraph shall be deposited in the smart and safe Arizona fund established by section 36-2856.

3. At any time during regular hours of operation, visit and inspect a marijuana establishment, marijuana testing facility or dual licensee to determine if it complies with this chapter and rules adopted pursuant to this chapter. The department shall make at least one unannounced visit annually to each facility licensed pursuant to this chapter.

4. Adopt any other rules that are necessary to ensure the safe and responsible cultivation, sale, processing, manufacture, testing and transport of marijuana and marijuana products.

C. Until the department adopts rules permitting and regulating delivery by marijuana establishments pursuant to subsection D of this section, delivery is unlawful under this chapter.

D. On or after January 1, 2023, the department may, and no later than January 1, 2025 the department shall, adopt rules to permit and regulate delivery by marijuana establishments. The rules shall:

1. Require that delivery and the marijuana and marijuana products to be delivered originate from a designated retail location of a marijuana establishment and only after an order is made with the marijuana establishment by a consumer.

2. Prohibit delivery to any property owned or leased by the United States, this state, a political subdivision of this state or the Arizona board of regents.
3. Limit the amount of marijuana and marijuana products based on retail price that may be in a delivery vehicle during a single trip from the designated retail location of a marijuana establishment.

4. Prohibit extra or unallocated marijuana or marijuana products in delivery vehicles.

5. Require that deliveries be made only by marijuana facility agents in unmarked vehicles that are equipped with a global positioning system or similar location tracking system and video surveillance and recording equipment, and that contain a locked compartment in which marijuana and marijuana products must be stored.

6. Require delivery logs necessary to ensure compliance with this subsection and rules adopted pursuant to this subsection.

7. Require inspections to ensure compliance with this subsection and rules adopted pursuant to this subsection.

8. Include any other provisions necessary to ensure safe and restricted delivery.

9. Require dual licensees to comply with the rules adopted pursuant to this subsection.

E. Except as provided in subsection D of this section, the department may not permit delivery of marijuana or marijuana products under this chapter by any individual or entity. In addition to any other penalty imposed by law, an individual or entity that delivers marijuana or marijuana products in a manner that is not authorized by this chapter shall pay a civil penalty of $20,000 per violation to the smart and safe Arizona fund established by section 36-2856. This subsection may be enforced by the attorney general.

F. All rules adopted by the department pursuant to this section shall be consistent with the purpose of this chapter.

G. The department may not adopt any rule that:

1. Prohibits the operation of marijuana establishments, either expressly or through requirements that make the operation of a marijuana establishment unduly burdensome.

2. Prohibits or interferes with the ability of a dual licensee to operate a marijuana establishment and a nonprofit medical marijuana dispensary at shared locations.

H. Notwithstanding section 41-192, the department may employ legal counsel and make an expenditure or incur an indebtedness for legal services for the purposes of:

1. Defending this chapter or rules adopted pursuant to this chapter.

2. Defending chapter 28.1 of this title or rules adopted pursuant to chapter 28.1 of this title.

I. The department shall deposit all license fees, application fees and renewal fees paid to the department pursuant to this chapter in the smart and safe Arizona fund established by section 36-2856.
J. On request, the department shall share with the department of revenue information regarding a marijuana establishment, marijuana testing facility or dual licensee, including its name, physical address, cultivation site and transaction privilege tax license number.

K. Notwithstanding any other law, the department may:
   1. License an independent third-party laboratory to also operate as a marijuana testing facility.
   2. Operate a marijuana testing facility.

L. The department shall maintain and publish a current list of all marijuana establishments and marijuana testing facilities by name and license number.

M. Notwithstanding any other law, the issuance of an occupational, professional or other regulatory license or certification to a person by a jurisdiction or regulatory authority outside this state does not entitle that person to be issued a marijuana establishment license, a marijuana testing facility license, or any other license, registration or certification under this chapter.

N. Until the department adopts rules as required by subsection A, paragraph 10 of this section:
   1. A marijuana testing facility is prohibited from having any direct or indirect familial relationship with or financial ownership interest in a marijuana establishment or related marijuana business entity or management company.
   2. A marijuana establishment is prohibited from having any direct or indirect familial relationship with or financial ownership interest in a marijuana testing facility or related marijuana business entity or management company.

Sec. 7. Section 41-1758.07, Arizona Revised Statutes, is amended to read:

41-1758.07. Level I fingerprint clearance cards; definitions

A. On receiving the state and federal criminal history record of a person who is required to be fingerprinted pursuant to this section, the fingerprinting division in the department of public safety shall compare the record with the list of criminal offenses that preclude the person from receiving a level I fingerprint clearance card. If the person's criminal history record does not contain any of the offenses listed in subsections B and C of this section, the fingerprinting division shall issue the person a level I fingerprint clearance card.

B. A person who is subject to registration as a sex offender in this state or any other jurisdiction or who is awaiting trial on or who has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit one or more of the following offenses in this state or the same or similar offenses in another state or jurisdiction is precluded from receiving a level I fingerprint clearance card:
   1. Sexual abuse of a vulnerable adult.
2. Incest.
3. Homicide, including first or second degree murder, manslaughter and negligent homicide.
4. Sexual assault.
5. Sexual exploitation of a minor.
7. Commercial sexual exploitation of a minor.
11. Felony child neglect.
13. Sexual conduct with a minor.
14. Molestation of a child.
15. Molestation of a vulnerable adult.
16. Dangerous crimes against children as defined in section 13-705.
17. Exploitation of minors involving drug offenses.
18. Taking a child for the purpose of prostitution as prescribed in section 13-3206.
20. Sex trafficking.
22. Production, publication, sale, possession and presentation of obscene items as prescribed in section 13-3502.
23. Furnishing harmful items to minors as prescribed in section 13-3506.
24. Furnishing harmful items to minors by internet activity as prescribed in section 13-3506.01.
25. Obscene or indecent telephone communications to minors for commercial purposes as prescribed in section 13-3512.
26. Luring a minor for sexual exploitation.
27. Enticement of persons for purposes of prostitution.
28. Procurement by false pretenses of person for purposes of prostitution.
29. Procuring or placing persons in a house of prostitution.
30. Receiving earnings of a prostitute.
31. Causing one's spouse to become a prostitute.
32. Detention of persons in a house of prostitution for debt.
33. Keeping or residing in a house of prostitution or employment in prostitution.
34. Pandering.
35. Transporting persons for the purpose of prostitution, polygamy and concubinage.
36. Portraying adult as a minor as prescribed in section 13-3555.
37. Admitting minors to public displays of sexual conduct as prescribed in section 13-3558.

38. Any felony offense involving contributing to the delinquency of a minor.

39. Unlawful sale or purchase of children.

40. Child bigamy.

41. Any felony offense involving domestic violence as defined in section 13-3601 except for a felony offense only involving criminal damage in an amount of more than two hundred fifty dollars $250 but less than one thousand dollars $1,000 if the offense was committed before June 29, 2009.

42. Any felony offense in violation of title 13, chapter 12 if committed within five years before the date of applying for a level I fingerprint clearance card.

43. Felony drug or alcohol related offenses if committed within five years before the date of applying for a level I fingerprint clearance card.

44. Felony indecent exposure.

45. Felony public sexual indecency.

46. Terrorism.

47. Any offense involving a violent crime as defined in section 13-901.03.

48. Trafficking of persons for forced labor or services.

C. A person who is awaiting trial on or who has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit one or more of the following offenses in this state or the same or similar offenses in another state or jurisdiction is precluded from receiving a level I fingerprint clearance card, except that the person may petition the board of fingerprinting for a good cause exception pursuant to section 41-619.55:

1. Any misdemeanor offense in violation of title 13, chapter 12.

2. Misdemeanor indecent exposure.


4. Aggravated criminal damage.

5. Theft.

6. Theft by extortion.

7. Shoplifting.

8. Forgery.

9. Criminal possession of a forgery device.

10. Obtaining a signature by deception.

11. Criminal impersonation.

12. Theft of a credit card or obtaining a credit card by fraudulent means.

13. Receipt of anything of value obtained by fraudulent use of a credit card.

14. Forgery of a credit card.
15. Fraudulent use of a credit card.
16. Possession of any machinery, plate or other contrivance or incomplete credit card.
17. False statement as to financial condition or identity to obtain a credit card.
18. Fraud by persons authorized to provide goods or services.
19. Credit card transaction record theft.
20. Misconduct involving weapons.
22. Depositing explosives.
23. Misconduct involving simulated explosive devices.
24. Concealed weapon violation.
25. Misdemeanor possession and misdemeanor sale of peyote.
26. Felony possession and felony sale of peyote if committed more than five years before the date of applying for a level I fingerprint clearance card.
27. Misdemeanor possession and misdemeanor sale of a vapor-releasing substance containing a toxic substance.
28. Felony possession and felony sale of a vapor-releasing substance containing a toxic substance if committed more than five years before the date of applying for a level I fingerprint clearance card.
29. Misdemeanor sale of precursor chemicals.
30. Felony sale of precursor chemicals if committed more than five years before the date of applying for a level I fingerprint clearance card.
31. Misdemeanor possession, misdemeanor use or misdemeanor sale of marijuana, dangerous drugs or narcotic drugs.
32. Felony possession, felony use or felony sale of marijuana, dangerous drugs or narcotic drugs if committed more than five years before the date of applying for a level I fingerprint clearance card.
33. Misdemeanor manufacture or misdemeanor distribution of an imitation controlled substance.
34. Felony manufacture or felony distribution of an imitation controlled substance if committed more than five years before the date of applying for a level I fingerprint clearance card.
35. Misdemeanor manufacture or misdemeanor distribution of an imitation prescription-only drug.
36. Felony manufacture or felony distribution of an imitation prescription-only drug if committed more than five years before the date of applying for a level I fingerprint clearance card.
37. Misdemeanor manufacture or misdemeanor distribution of an imitation over-the-counter drug.
38. Felony manufacture or felony distribution of an imitation over-the-counter drug if committed more than five years before the date of applying for a level I fingerprint clearance card.
39. Misdemeanor possession or misdemeanor possession with intent to use an imitation controlled substance.
40. Felony possession or felony possession with intent to use an imitation controlled substance if committed more than five years before the date of applying for a level I fingerprint clearance card.
41. Misdemeanor possession or misdemeanor possession with intent to use an imitation prescription-only drug.
42. Felony possession or felony possession with intent to use an imitation prescription-only drug if committed more than five years before the date of applying for a level I fingerprint clearance card.
43. Misdemeanor possession or misdemeanor possession with intent to use an imitation over-the-counter drug.
44. Felony possession or felony possession with intent to use an imitation over-the-counter drug if committed more than five years before the date of applying for a level I fingerprint clearance card.
45. Misdemeanor manufacture of certain substances and drugs by certain means.
46. Felony manufacture of certain substances and drugs by certain means if committed more than five years before the date of applying for a level I fingerprint clearance card.
47. Adding poison or other harmful substance to food, drink or medicine.
48. A criminal offense involving criminal trespass under title 13, chapter 15.
49. A criminal offense involving burglary under title 13, chapter 15.
50. A criminal offense under title 13, chapter 23, except terrorism.
51. Misdemeanor offenses involving child neglect.
52. Misdemeanor offenses involving contributing to the delinquency of a minor.
53. Misdemeanor offenses involving domestic violence as defined in section 13-3601.
54. Felony offenses involving domestic violence if the offense only involved criminal damage in an amount of more than two hundred fifty dollars $250 but less than one thousand dollars $1,000 and the offense was committed before June 29, 2009.
55. Arson.
56. Felony offenses involving sale, distribution or transportation of, offer to sell, transport or distribute or conspiracy to sell, transport or distribute marijuana, dangerous drugs or narcotic drugs if committed more than five years before the date of applying for a level I fingerprint clearance card.
57. Criminal damage.
58. Misappropriation of charter school monies as prescribed in section 13-1818.
59. Taking identity of another person or entity.
60. Aggravated taking identity of another person or entity.
61. Trafficking in the identity of another person or entity.
62. Cruelty to animals.
63. Prostitution, as prescribed in section 13-3214.
64. Sale or distribution of material harmful to minors through vending machines as prescribed in section 13-3513.
65. Welfare fraud.
66. Any felony offense in violation of title 13, chapter 12 if committed more than five years before the date of applying for a level I fingerprint clearance card.
67. Kidnapping.
68. Robbery, aggravated robbery or armed robbery.

D. A person who is awaiting trial on or who has been convicted of committing or attempting to commit a misdemeanor violation of section 28-1381, 28-1382 or 28-1383 in this state or the same or a similar offense in another state or jurisdiction within five years from the date of applying for a level I fingerprint clearance card is precluded from driving any vehicle to transport employees or clients of the employing agency as part of the person's employment. The division shall place a notation on the level I fingerprint clearance card that indicates this driving restriction. This subsection does not preclude a person from driving a vehicle alone as part of the person's employment.

E. Notwithstanding subsection C of this section, on receiving written notice from the board of fingerprinting that a good cause exception was granted pursuant to section 41-619.55, the fingerprinting division shall issue a level I fingerprint clearance card to the applicant.

F. If the fingerprinting division denies a person's application for a level I fingerprint clearance card pursuant to subsection C of this section and a good cause exception is requested pursuant to section 41-619.55, the fingerprinting division shall release, on request by the board of fingerprinting, the person's criminal history record to the board of fingerprinting.

G. A person shall be granted a level I fingerprint clearance card pursuant to this section if either of the following applies:

1. An agency granted a good cause exception before August 16, 1999 and no new precluding offense is identified. The fingerprint clearance card shall specify only the program that granted the good cause exception. On the request of the applicant, the agency that granted the prior good cause exception shall notify the fingerprinting division in writing of the date on which the prior good cause exception was granted, the date of the
conviction and the name of the offense for which the good cause exception was granted.

2. The board granted a good cause exception and no new precluding offense is identified.

H. The licensee or contract provider shall assume the costs of fingerprint checks conducted pursuant to this section and may charge these costs to persons who are required to be fingerprinted.

I. A person who is under eighteen years of age or who is at least ninety-nine years of age is exempt from the level I fingerprint clearance card requirements of this section. At all times the person shall be under the direct visual supervision of personnel who have valid level I fingerprint clearance cards.

J. The fingerprinting division shall conduct periodic state criminal history records checks and may conduct federal criminal history records checks when authorized pursuant to federal law for the purpose of updating the clearance status of current level I fingerprint clearance cardholders pursuant to this section and may notify the board of fingerprinting and the agency of the results of the records check.

K. The fingerprinting division shall revoke a person's level I fingerprint clearance card on receipt of a written request for revocation from the board of fingerprinting pursuant to section 41-619.55.

L. If a person's criminal history record contains an offense listed in subsection B or C of this section and the final disposition is not recorded on the record, the division shall conduct research to obtain the disposition within thirty business days after receipt of the record. If the division cannot determine, within thirty business days after receipt of the person's state and federal criminal history record information, whether the person is awaiting trial on or has been convicted of committing or attempting, soliciting, facilitating or conspiring to commit any of the offenses listed in subsection B or C of this section in this state or the same or a similar offense in another state or jurisdiction, the division shall not issue a level I fingerprint clearance card to the person. If the division is unable to make the determination required by this section and does not issue a level I fingerprint clearance card to a person, the person may request a good cause exception pursuant to section 41-619.55.

M. If after conducting a state and federal criminal history records check the fingerprinting division determines that it is not authorized to issue a level I fingerprint clearance card to an applicant, the division shall notify the agency that the fingerprinting division is not authorized to issue a level I fingerprint clearance card. This notice shall include the criminal history information on which the denial was based. This criminal history information is subject to dissemination restrictions pursuant to section 41-1750 and Public Law 92-544.
N. The fingerprinting division is not liable for damages resulting from:
   1. The issuance of a level I fingerprint clearance card to an applicant who is later found to have been ineligible to receive a level I fingerprint clearance card at the time the card was issued.
   2. The denial of a level I fingerprint clearance card to an applicant who is later found to have been eligible to receive a level I fingerprint clearance card at the time issuance of the card was denied.

O. Notwithstanding any law to the contrary, an individual may apply for and receive a level I fingerprint clearance card pursuant to this section to satisfy a requirement that the person have a valid fingerprint clearance card issued pursuant to section 41-1758.03.

P. Notwithstanding any law to the contrary, except as prescribed pursuant to subsection Q of this section, an individual who receives a level I fingerprint clearance card pursuant to this section also satisfies a requirement that the individual have a valid fingerprint clearance card issued pursuant to section 41-1758.03.

Q. Unless a cardholder commits an offense listed in subsection B or C of this section after June 29, 2009, a fingerprint clearance card issued pursuant to section 41-1758.03 before June 29, 2009 and its renewals are valid for all requirements for a level I fingerprint clearance card except those relating to the requirements of section 8-105 or 8-509. A fingerprint clearance card issued before June 29, 2009 to meet the requirements of section 8-105 or 8-509 and its renewals are valid after June 29, 2009 to meet all requirements for a level I fingerprint clearance card, including the requirements of section 8-105 or 8-509, if the cardholder has been certified by the court to adopt or has been issued a foster home license before June 29, 2009.

R. The issuance of a level I fingerprint clearance card does not entitle a person to employment.

S. For the purposes of this section:
   1. "Person" means a person who is fingerprinted pursuant to:
      (a) Section 3-314, 8-105, 8-463, 8-509, 8-802, 17-215, 36-207, 36-594.01, 36-594.02, 36-882, 36-883.02, 36-897.01, 36-897.03, 36-2819, 36-2855, 41-619.52, 41-619.53, 41-1964, 41-1967.01, 41-1968, 41-1969 or 46-141.
      (b) Subsection O of this section.
   2. "Renewal" means the issuance of a fingerprint clearance card to an existing fingerprint clearance cardholder who applies before the person's existing fingerprint clearance card expires.

Sec. 8. Rulemaking exemption; department of health services
Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, for the purposes of this act, the department of health services is exempt from the rulemaking requirements of title 41, chapters 6 and 6.1, Arizona Revised Statutes, until January 1, 2022.
except that the department shall provide the public at least thirty days
to comment on the proposed rules.

Sec. 9. Requirements for enactment; three-fourths vote
Pursuant to article IV, part 1, section 1, Constitution of Arizona,
sections 36-2803, 36-2804.01, 36-2816, 36-2819, 36-2821 and 36-2854,
Arizona Revised Statutes, as amended by this act, and section 8 of this
act are effective only on the affirmative vote of at least three-fourths
of the members of each house of the legislature.

Sec. 10. Emergency
This act is an emergency measure that is necessary to preserve the
public peace, health or safety and is operative immediately as provided by
law.

APPROVED BY THE GOVERNOR JULY 10, 2021.

DEPARTMENT OF HEALTH SERVICES
Title 9, Chapter 11

Amend: R9-11-101, R9-11-201, R9-11-202, R9-11-203, R9-11-205,
R9-11-301, R9-11-402, R9-11-502

New Article: Article 6

GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 10, 2022

SUBJECT: Department of Health Services

Title 9, Chapter 11

Amend: R9-11-101, R9-11-201, R9-11-202, R9-11-203, R9-11-205,
R9-11-301, R9-11-402, R9-11-502

New Article: Article 6


Summary:

This Regular Rulemaking from the Department of Health Services relates to rules in Title 9, Chapter 11 regarding Health Care Institution Facility Data. In this regular rulemaking the Department seeks to amend its rules to comply with Laws 2018, Ch. 293, which amended A.R.S. 36-104. Specifically, the revised statute requires the Department to adopt rules “prescribing the designated database information to be collected by health professional regulatory boards” pursuant to A.R.S. Title 32, Chapter 32, Article 5. Additionally, Laws 2019, Ch. 215, added A.R.S. § 36-171 to require the Department to adopt rules to establish and maintain the health care professionals workforce data repository containing the designated database information collected and transferred to the Department pursuant to A.R.S. Title 32, Chapter 32, Article 5. The Department is establishing a new fee of $100 for the release of designated database information, pursuant to A.R.S. Title 36, Chapter 1, Article 3.
The Department received approval from the rulemaking moratorium to initiate this rulemaking on August 2, 2019, and final approval to submit to the Council on June 22, 2022.

1. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   Yes, the Department cites to both general and specific statutory authority.

2. **Do the rules establish a new fee or contain a fee increase?**

   Yes, the rules establish a new fee of $100 for the release of designated database information, pursuant to A.R.S. Title 36, Chapter 1, Article 3.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   The Department did not review or rely on any study for this rulemaking.

4. **Summary of the agency’s economic impact analysis:***

   The Department estimates that the cost to the Department of setting up and implementing a health professional’s workforce data repository to comply with Laws 2018, Ch. 293 and Laws 2019, Ch. 215, may be substantial. The Department also anticipates that preparing and providing designated database information and summary reports to requesters may cause the Department to incur substantial costs as well. The Department anticipates that requesting, storing, and transferring to the Department the indicated information may result in a substantial cost to a Board. Persons requesting designated database information and summary reports may incur as much as a moderate cost for the information or report. Individuals applying to or regulated by one of the Boards are subject to the Board’s request for the information. The Department estimates that an individual responding to the Board’s request for this information would incur minimal costs for the time they spend providing the information. The Department anticipates that the general public may also receive a significant benefit from the rulemaking by increasing the information upon which persons may make decisions related to the locations and staffing of health care institutions.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   The Department has analyzed the costs and benefits of the rulemaking and believes there are no less intrusive or less costly alternatives for achieving the purpose of the rule.
6. **What are the economic impacts on stakeholders?**

The Department anticipates that the rulemaking may affect the Department; the Boards, as defined in A.R.S. § 32-3249; those persons requesting designated database information and summary reports; health care institutions reporting to the Department under Articles 2 through 5; individuals applying to or regulated by a Board; and the general public.

The Department is establishing a permanent repository that will house the annual data sets in perpetuity to meet the statutory requirements. The Department estimates that the Department incurred approximately $100,000 in costs for these activities. The Department must prepare designated database information into an annual data set. The Department estimates that it may require at least one FTE for at least six months to create the annual data set. Thus, the Department’s costs to produce the annual data set are expected to be substantial. In addition, the Department anticipates that some requestors will want a customized data set, tailored to their specific needs. The costs to create these summary reports will vary depending on what is requested. The rules specify in R9-11-604(C)(2)(b) and (D)(2) that the fee for a customized data set or a report summarizing the data will be determined based on the costs to the Department in producing the reports, which are expected to be minimal for each report but may be substantial in the aggregate for both costs and benefits.

The health profession regulatory boards affected by these rules include the Arizona Medical Board, Board of Nursing, Arizona Board of Osteopathic Examiners in Medicine and Surgery, Board of Physical Therapy, Board of Psychologist Examiners, and Board of Behavioral Health Examiners. The Department anticipates that requesting, storing, and transferring to the Department the indicated information may result in a substantial cost to a Board, the bulk of which is due to statutory requirements rather than the rules.

The rules currently in 9 A.A.C. 11 implement several statutes related to the reporting of data about health care institutions. The Department believes that the changes may improve the rules, make them more effective, and reduce the burden on reporting health care institutions, thus, providing a significant benefit to a reporting health care institution.

City planners and/or local governments require data upon which to make decisions that affect the areas under their jurisdictions. The Department anticipates that increasing the availability of information upon which persons may make decisions related to the locations and staffing of health care institutions may provide a significant benefit to those requesting designated database information and summary reports. Those persons requesting designated database information and summary reports may incur as much as a moderate cost for the information or report, but the amount of these costs is at the discretion of the requester.
The Department anticipates that the rules may provide a significant benefit to individuals applying to or regulated by a Board and to the general public.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department indicates they removed an incorrect cross-reference in R9-11-602 (B) and corrected minor typographical and grammatical errors. Council staff does not find the changes to be a substantial change, considered as a whole, from the proposed rules.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department indicates they did not receive any comments.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a general permit or license.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws to the rules.

11. **Conclusion**

As mentioned above, the Department seeks to amend the rules in order to comply with recent statutory changes. The Department is seeking the standard 60-day delayed effective date for this rulemaking.

Council staff recommends approval of this rulemaking.
VIA EMAIL: grrc@azdoa.gov
Nicole Sorns, Chair
Governor’s Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Department of Health Services, 9 A.A.C. 11, Regular Rulemaking

Dear Ms. Sorns:

1. **The close of record date:** March 7, 2022

2. **Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:**
   The rulemaking for 9 A.A.C. 11 partially relates to a five-year-review report approved by the Council on December 1, 2020. In addition, the rulemaking adopts rules related to the health professional workforce database to comply with Laws 2018, Ch. 293, and Laws 2019, Ch. 215.

3. **Whether the rulemaking establishes a new fee and, if so, the statute authorizing the fee:**
   The rulemaking does establish a new fee, authorized by A.R.S. Title 36, Chapter 1, Article 3.

4. **Whether the rulemaking contains a fee increase:**
   The rulemaking does not contain a fee increase.

5. **Whether an immediate effective date is requested pursuant to A.R.S. 41-1032:**
   No, the Department is requesting the normal 60-day delay after approval for the effective date for the rules.

The Department is requesting that the rules be heard at the Council meeting on September 7, 2022.

The Department certifies that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on in its evaluation of or justification for the rule.

The Department certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.
The following documents are enclosed:
   a. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of the rule;
   b. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055; and
   c. General and specific statutes authorizing the rules.

The Department’s point of contact for questions about the rulemaking documents is Ruthann Smejkal at Ruthann.Smejkal@azdhs.gov.

Sincerely,

[Signature]

Robert Lane
Director’s Designee

RL: rms

Enclosures
NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 11. DEPARTMENT OF HEALTH SERVICES
HEALTH CARE INSTITUTION FACILITY DATA

PREAMBLE

1. **Article, Part or Sections Affected (as applicable)** | **Rulemaking Action**
--- | ---
R9-11-101 | Amend
R9-11-201 | Amend
R9-11-202 | Amend
R9-11-203 | Amend
R9-11-205 | Amend
R9-11-301 | Amend
R9-11-402 | Amend
R9-11-502 | Amend
Article 6 | New Article
R9-11-601 | New Article
R9-11-602 | New Section
R9-11-603 | New Section
R9-11-604 | New Section

2. **Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**
   Authorizing statutes: A.R.S. § 36-136(G)
   Implementing statutes: A.R.S. §§ 36-125.04, 36-125.05, 36-436, 36-436.01, 36-436.02, 36-436.03, 36-2901.08

3. **The effective date of the rules:**
The Arizona Department of Health Services (Department) requests the normal 60-day delayed effective date for this rulemaking.

4. **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. 569, March 27, 2020
   Notice of Rulemaking Docket Opening: 26 A.A.R. 3058, November 27, 2020
   Notice of Rulemaking Docket Opening: 27 A.A.R. 2701, November 19, 2021
5. **The agency's contact person who can answer questions about the rulemaking:**

Name: Joseph Spadafino, Manager
Address: Arizona Department of Health Services
Hospital Data and Systems
150 N. 18th Ave., Suite 550
Phoenix, AZ  85007-3248
Telephone: (602) 542-8064
Fax: (602) 364-0082
E-mail: Joseph.Spadafino@azdhs.gov

or

Name: Stephanie Elzenga, Interim Chief
Address: Arizona Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ  85007
Telephone: (602) 542-1020
Fax: (602) 364-1150
E-mail: Stephanie.Elzenga@azdhs.gov

6. **An agency's justification and reason why a rule should be made, amended, repealed or renum-bered, to include an explanation about the rulemaking:**

Laws 2018, Ch. 293, amended Arizona Revised Statutes (A.R.S.) § 36-104 to require the Arizona Department of Health Services (Department) to adopt rules “prescribing the designated database information to be collected by health professional regulatory boards” pursuant to A.R.S. Title 32, Chapter 32, Article 5. Laws 2019, Ch. 215, added A.R.S. § 36-171 to require the Department to adopt rules to establish and maintain the health care professionals workforce data repository containing the designated database information collected and transferred to the Department pursuant to A.R.S. Title 32, Chapter 32, Article 5. The Department is adopting these rules, consistent with recommendations of the Health Care Professionals Workforce Data Repository Advisory Committee, in Arizona Administrative Code (A.A.C.) Title 9, Chapter 11, which currently contains Articles implementing several statutes related to the reporting of data about health care institutions. In addition, the Department is making several changes to the rules in these Articles that were identified as part of a review of the rules and would improve the rules, make them more effective, and reduce the burden on reporting health care institutions. After receiving an exception from the rulemaking moratorium established by Executive Order 2019-01 to adopt rules to comply with
Laws 2018, Ch. 293, and Laws 2019, Ch. 215, and approval to add to this rulemaking changes to the other Articles in the Chapter identified in a five-year-review report, the Department is proceeding with the rulemaking.

7. **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 Department did not review or rely on any study for this rulemaking.

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

   Not applicable

9. **The summary of the economic, small business, and consumer impact:**

   The Department anticipates that the rulemaking may affect the Department; the Boards, as defined in A.R.S. § 32-3249; those persons requesting designated database information and summary reports; health care institutions reporting to the Department under Articles 2 through 5; individuals applying to or regulated by a Board; and the general public. Annual costs/revenues changes are designated as minimal when more than $0 and $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification.

   The Department believes that having rules in Articles 2 through 5 that are clearer and easier to understand may provide a significant benefit to the Department and to health care institutions reporting to the Department under Articles 2 through 5 of the Chapter. The Department estimates that the cost to the Department of setting up and implementing a health professionals workforce data repository, to comply with Laws 2018, Ch. 293 and Laws 2019, Ch. 215, may be substantial. However, these costs are the result of the statutory changes, rather than the rules. The Department also anticipates that preparing and providing designated database information and summary reports to requesters may cause the Department to incur substantial costs as well. These costs will be off-set by the fees charged to requesters of designated database information and summary reports.

   The Arizona Medical Board, Board of Nursing, Arizona Board of Osteopathic Examiners in Medicine and Surgery, Board of Physical Therapy, Board of Psychologist Examiners, and Board of Behavioral Health Examiners are the health profession regulatory boards affected by these rules. The Department anticipates that requesting, storing, and transferring to the Department the indicated information may result in a substantial cost to a Board, the bulk of which is due to statutory requirements rather than the rules. The Department has included in the rules provisions to minimize or mitigate these costs.
The Department believes that many persons, including local governments, may be requesters of designated database information and summary reports. These persons may find information about the number, types, and distribution of health professionals useful in achieving their various goals, but obtaining the data de novo may be costly and difficult, inaccurate, or impossible. The Department anticipates that having access to information contained in the health professionals workforce data repository may provide a significant benefit to those requesting designated database information and summary reports. Those persons requesting designated database information and summary reports may incur as much as a moderate cost for the information or report, but the amount of these costs is at the discretion of the requester.

Under the rules, individuals applying to or regulated by one of the Boards listed above are subject to the Board’s request for the information specified in R9-11-602(B) at the time of initial application or renewal. Much of the information being requested is already being required by some of the Boards. If a Board collected none of the information specified in R9-11-602(B) as part of its regulatory function, the Department estimates that an individual responding to the Board’s request for this information would incur minimal costs for the time they spend providing the information. These individuals may receive a significant benefit from actions taken by a requestor of designated database information based on the information received. The Department anticipates that the general public may also receive a significant benefit from the rulemaking by increasing the information upon which persons may make decisions related to the locations and staffing of health care institutions.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:
Between the proposed rulemaking and final rulemaking, the Department removed an incorrect cross-reference in R9-11-602(B) and corrected minor typographical or grammatical errors.

11. An agency’s summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:
During the formal public comment period, the Department received no written comments about the rules and no regulated entities or members of the public attended the oral proceeding held on March 7, 2022, either in person or through teleconferencing.

12. 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:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:
Not applicable
b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:
Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:
No business competitiveness analysis was received by the Department.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:
Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:
Not applicable

15. The full text of the rules follows:
ARTICLE 1. DEFINITIONS

Section
R9-11-101. Definitions

ARTICLE 2. ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

Section
R9-11-201. Definitions
R9-11-202. Hospital Annual Financial Statement
R9-11-203. Hospital Uniform Accounting Report
R9-11-205. Hospice Uniform Accounting Report

ARTICLE 3. RATES AND CHARGES SCHEDULES

Section
R9-11-301. Definitions

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING

Section
R9-11-402. Reporting Requirements

ARTICLE 5. EMERGENCY DEPARTMENT DISCHARGE REPORTING

Section
R9-11-502. Reporting Requirements

ARTICLE 6. HEALTH PROFESSIONALS WORKFORCE DATABASE

Section
R9-11-601. Definitions
R9-11-602. Designated Database Information
R9-11-603. Transfer of Data from a Board
R9-11-604. Requests for Release of Designated Database Information and Reports
ARTICLE 1. DEFINITIONS

R9-11-101. Definitions

In this Chapter, unless otherwise specified:

1. “Admission” or “admitted” means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
3. “Allowance” means a charity care discount, self-pay discount, or contractual adjustment.
4. “Arizona facility ID” means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.
5. “Assisted living facility” means the same as in A.R.S. § 36-401.
6. “Attending provider” means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
7. “Available bed” means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
8. “Bill” means a statement for money owed to a health care institution for the provision of the health care institution’s services.
9. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
10. “Calendar day” means any day of the week, including a Saturday or a Sunday.
11. “Cardiopulmonary resuscitation” means the same as in A.R.S. § 36-3251.
12. “Charge” means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.
13. “Charge source” means the unit within a health care institution that provided services to an individual for which the individual’s payer source is billed.
14. “Charity care” means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
16. “Chief financial officer” means an individual who is responsible for the financial records of a health care institution.
17. “Classification” means a designation that indicates the types of services a hospital provides.
18. “Clinical evaluation” means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.

19. “Code” means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.

20. “Commodity” means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.

21. “Contractual adjustment” means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.

22. “Control number” means a unique number assigned by a hospital for an individual’s specific episode of care.


24. “Designee” means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.

25. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual’s current medical condition.

26. “Discharge” means a health care institution’s termination of services to a patient or resident for a specific episode of care.

27. “Discharge status” means the disposition of a patient, including whether the patient was:
   a. Discharged Was discharged home,
   b. Transferred Was transferred to another health care institution, or
   c. Died.

28. “DNR” means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient’s heart stops beating.

29. “E-code” means an International Classification of Diseases code that is used:
   a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
   b. To further designate the individual’s injury or illness as being caused by events such as:
      i. An external cause of injury, such as a car accident;
      ii. A poisoning; or
      iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.
30. “Electronic” means the same as in A.R.S. § 36-301.
32. “Emergency department” means the unit within a hospital that is designed for the provision of emergency services.
34. “Episode of care” means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.
35. “Fiscal year” means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.
36. “Governing authority” means the same as in A.R.S. § 36-401.
37. “Health care institution” means the same as in A.R.S. § 36-401.
38. “Health-related services” means the same as in A.R.S. § 36-401.
39. “Home health agency” means the same as in A.R.S. § 36-151.
40. “Home health services” means the same as in A.R.S. § 36-151.
41. “Home office” means the person that is the owner of and controls the functioning of a nursing care institution.
42. “Hospice” means the same as in A.R.S. § 36-401.
44. “Hospital administrator” means the same as “chief administrative officer” or “administrator” in A.A.C. R9-10-201 R9-10-101.
45. “Hospital services” means the same as in A.A.C. R9-10-201.
46. “Inpatient” means the same as in A.A.C. R9-10-201 an individual admitted to a hospital and billed as an inpatient according to the hospital’s policies and procedures.
47. “International Classification of Diseases Code” means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
48. “Licensed capacity” means the same as in A.R.S. § 36-401.
49. “Management company” means an entity that:
   a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution,
   b. Takes direction from the governing authority of the nursing care institution, and
   c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
50. “Medical practitioner” means an individual who is:
   a. Licensed:
i. As a physician;
ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or

b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.

§4-50. “Medical record number” means a unique number assigned by a hospital to an individual for identification purposes.

§2-51. “Medical services” means the same as in A.R.S. § 36-401.

§3-52. “Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.

§4-53. “National provider identifier” means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.

§5-54. “Newborn” means a human:

a. Whose birth took place in the reporting hospital, or

b. Who was:
   i. Born outside a hospital,
   ii. Admitted to the reporting hospital within 24 hours of birth, and
   iii. Admitted to the reporting hospital before being admitted to any other hospital.

§6-55. “Nursing care institution” means the same as in A.R.S. § 36-446.

§7-56. “Nursing care institution administrator” means the same as in A.R.S. § 36-446.

§8-57. “Nursing services” means the same as in A.R.S. § 36-401.


60. “Payer source” means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.

61-60. “Physician” means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a
62. “Principal diagnosis” means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.

63. “Principal procedure” means the procedure judged by an individual working on behalf of a hospital to be:
   a. The most significant procedure performed during an episode of care, or
   b. The procedure most closely associated with a patient’s principal diagnosis.

64. “Priority of visit” means the urgency with which a patient required medical services during an episode of care.

65. “Procedure” means a set of activities performed on a patient that:
   a. Is intended to diagnose or treat a disease, illness, or injury;
   b. Requires the individual performing the set of activities be trained in the set of activities; and
   c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.

66. “Prospective payment system” means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.

67. “Refer” means to direct an individual to a health care institution for services provided by the health care institution.

68. “Referral source” means a code designating the entity that referred or transferred a patient to a hospital.

69. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.

70. “Reporting period” means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.

71. “Residence” means the place where an individual lives, such as:
   a. A private home,
   b. A nursing care institution, or
   c. An assisted living facility.


73. “Revenue code” means a code for a unit of service that a hospital includes on a bill for hospital services.
“Secondary diagnosis” means any diagnosis for an individual other than the principal diagnosis.

“Self-pay discount” means a reduction in charges billed to an individual.

“Service” means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.

“Supportive services” means the same as in A.R.S. § 36-151.

“Transfer” means discharging an individual from a health care institution so the individual may be admitted to another health care institution.

“Trauma center” means the same as in:

a. A.R.S. § 36-2201, or
b. A.R.S. § 36-2225.

“Treatment” means the same as in A.A.C. R9-10-101.

“Type of” means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:

a. An employee or contracted worker;
b. An accounting concept, such as asset, liability, or revenue;
c. A non-covered ancillary charge;
d. A payer source;
e. A charge source;
f. A medical condition; or
g. A service.

“Type of bed” means a category of available bed that specifies the services provided to an individual occupying the available bed.

“Unit” means an area within a health care institution that is designated by the health care institution to provide a specific type of service.

“Unit of service” means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.

“Written notice” means a document that is provided:

a. In person,
b. By delivery service,
c. By facsimile transmission,
d. By electronic mail, or
e. By mail.
ARTICLE 2. ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

R9-11-201. Definitions

In this Article, unless otherwise specified:

1. “Accredited” means the same as in A.R.S. § 36-422.
2. “ALTCS” means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. “Asset” means the same as “asset” in generally accepted accounting principles.
4. “Assisted living facility-based hospice” means a hospice that operates as a part of an assisted living facility.
5. “Audit” means the same as “audit” in generally accepted accounting principles.
6. “Bereavement services” means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual’s death.
7. “Building improvement” means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
8. “Caseload” means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
10. “Chaplain” means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient’s family.
11. “Continuous care” means hospice services provided in a patient’s residence to a patient who requires nursing services to be available 24 hours a day.
12. “Contracted worker” means an individual who:
   a. Performs:
      i. Hospital services in a hospital,
      ii. Nursing services or health-related services in a nursing care institution,
      iii. Hospice services for a hospice, or
      iv. Labor as a medical record coder or transcriptionist for a hospital; and
   b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.
13. “Covered services” means hospice services that are provided to an individual by a hospice and are paid for by a payer source.
14.13. “Daily census” means a count of the number of patients to whom hospice services were provided during a 24-hour period.

15.14. “Direct care” means services provided to a resident that require hands-on contact with the resident.


17.16. “Employee” means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.

18.17. “Employee-related expenses” means costs incurred by an employer to pay for the employer’s portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.

19.18. “Equity” means the same as “equity” in generally accepted accounting principles.

20.19. “Expense” means the same as “expense” in generally accepted accounting principles.

21.20. “Free-standing” means that a health care institution does not operate as part of another health care institution.

22.21. “FTE” means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.

23.22. “Generally accepted accounting principles” means the set of financial reporting standards administered by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or other specialized bodies dealing with accounting and auditing matters.

24.23. “Health professional” means the same as in A.R.S. § 32-3201.

25. “Home health agency-based hospice” means a hospice that operates as part of a home health agency.

26.24. “Hospice administrator” means the chief administrative officer for a hospice.

27.25. “Hospice chief financial officer” means an individual who is responsible for the financial records of a hospice.


29.27. “Hospice service services” means the same as in A.A.C. R9-10-801 activities described in A.A.C. R9-10-612.

30.28. “Hospice service agency” means the same as in A.R.S. § 36-401.

31. “Hospital-based hospice” means a hospice that operates as a part of a hospital.

32.29. “Income” means the same as “income” in generally accepted accounting principles.

33.30. “Inpatient services” means the same as in A.A.C. R9-10-801 sleeping accommodations and assistance, such as personal care and food preparation, provided to a patient at one of the following health care institutions:
a. A hospice inpatient facility licensed under 9 A.A.C. 10, Article 6;
b. A hospital licensed under 9 A.A.C. 10, Article 2; or
c. A nursing care institution licensed under 9 A.A.C. 10, Article 4.

34. “Inpatient surgery” means surgery that requires a patient to receive inpatient services in a hospital.

35. “Level of care” means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.

36. “Liability” means the same as “liability” in generally accepted accounting principles.

37. “Licensed nurse” means a registered nurse practitioner, registered nurse, or practical nurse.


39. “Median length of stay” means the midpoint in the number of patient care days for all patients who were discharged from a hospice during a specific period of time.

40. “Medicaid” means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.

41. “Medical record coder” means an individual who assigns codes to a patient’s diagnoses and procedures for billing purposes.

42. “Medical record transcriptionist” means an individual who copies and edits dictation from medical practitioners into medical records.

43. “Medical records” mean the same as in A.R.S. § 12-2291.

44. “Medicare cost report” means the annual financial and statistical documents submitted to the United States Department of Health and Human Services as required by Title XVIII of the Social Security Act.

45. “Medicare-certified” means that a health care institution is authorized by the United States Department of Health and Human Services to bill Medicare for services provided to patients or residents who are eligible to receive Medicare.

46. “Midnight census” means a count of the number of patients or residents in a health care institution at 12:00 a.m.

47. “Net assets” means the same as “net assets” in generally accepted accounting principles.

48. “Non-covered ancillary services” means activities, such as rehabilitation services, laboratory tests, or x-rays, provided to an individual in a health care institution that are paid for by:

a. A payer source other than ALTCS, or

b. ALTCS to an entity that is not a health care institution.

49. “Nursery patient” means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital’s licensed capacity.
50. “Nursing care institution-based hospice” means a hospice that operates as a part of a nursing care institution.

51. “Nursing personnel” means the individuals authorized by a health care institution to provide nursing services to a patient or resident.

52. “Occupancy rate” means the midnight census divided by the number of available beds, expressed as a percent.

53. “Operating expense” means the same as “operating expense” in generally accepted accounting principles.

54. “Outpatient hospice services” means hospice services provided at a location outside a hospice inpatient facility.

55. “Outpatient surgery” means surgery that does not require a patient to receive inpatient services in a hospital.


57. “Patient care day” means a calendar day during which a hospice provides hospice services to a patient.

58. “Patient day” means a period during which a patient received inpatient services with:
   a. The time between the midnight census on two successive calendar days counting as one period, and
   b. The day of discharge being counted only when the patient is admitted and discharged on the same day.

59. “Person” means the same as in A.R.S. § 41-1001.

60. “Practical nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.

61. “Registered nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.


63. “Resident day” means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:
   a. The time between the midnight census on two successive calendar days counting as one period, and
   b. The day of discharge being counted only when the resident is admitted and discharged on the same day.

64. “Respite care services” means the same as in A.R.S. § 36-401.

65. “Revenue” means the same as “revenue” in generally accepted accounting principles.
“Routine home care” means hospice services provided in a patient’s residence to a patient who does not require nursing services to be available 24 hours a day.

“Rural” means the same as in A.R.S. § 36-2171.

“Self-pay” means that charges for hospice services are billed to an individual.

“Social worker” means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.

“Statement of cash flows” means the same as “statement of cash flows” in generally accepted accounting principles.

“Surgery” means the excision of a part of a patient’s body or the incision into a patient’s body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.

“Turnover rate” means:

a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the hospital during a reporting period by the average number of individuals employed during the reporting period; or

b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a reporting period by the average number of employees during the reporting period.

“Uniform accounting report” means a document that meets the requirements of A.R.S. § 36-125.04 and contains the information required in R9-11-203 for hospitals, R9-11-204 for nursing care institutions, and R9-11-205 for hospices.

“Unscheduled medical services” means the same as in A.R.S. § 36-401.

“Urban” means an area not defined as “rural.”

“Urgent care unit” means a facility under a hospital’s license that is:

a. Located within one-half mile of the hospital, and

b. Designated by the hospital for the provision of unscheduled medical services for medical conditions that are of a less critical nature than emergency medical conditions.

“Vacancy rate” means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital’s reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital’s reporting period.


R9-11-202. Hospital Annual Financial Statement

A. A hospital administrator or designee shall submit to the Department, no later than 120 calendar days after the ending date of the hospital's fiscal year:
1. An annual financial statement prepared according to generally accepted accounting principles;
2. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (A)(1); and
3. An attestation, signed and dated by the hospital administrator or designee, that the hospital is not passing on the cost of the hospital assessment, established in A.R.S. § 36-2901.08(A), to a patient or a third-party payor that is responsible for paying for the patient’s care.

B. If a hospital is part of a group of health care institutions that prepares a combined annual financial statement and is included in the combined annual financial statement, the hospital administrator or designee may submit the combined annual financial statement if the combined annual financial statement:
   1. Is prepared according to generally accepted accounting principles,
   2. Identifies the hospital, and
   3. Contains a financial statement specific to the hospital.

C. The Department shall grant a hospital a 30-day extension for submitting an annual financial statement and report of the audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:
   1. Includes the name, physical address, mailing address, and telephone number of the hospital;
   2. Includes the name, telephone number, mailing address, and e-mail address of:
      a. The hospital administrator; and
      b. An individual, in addition to the hospital administrator, who may be contacted about the extension request;
   3. Includes the date the hospital's annual financial statement and audit of the annual financial statement is due to the Department;
   4. Specifies that the hospital is requesting a 30-day extension from submitting the annual financial statement and report of the audit of the annual financial statement required in subsection (A); and
   5. Is submitted to the Department at least 30 calendar days before the annual financial statement and report of the audit of the annual financial statement is due to the Department.

D. The Department shall send a written notice of approval of a 30-day extension to a hospital that submits a request for an extension that meets the requirements specified in subsection (C) within seven business days after receiving the request.

E. If a request by a hospital administrator or designee for a 30-day extension does not meet the requirements specified in subsection (C), the Department shall provide to the hospital a written notice that specifies the missing or incomplete information. If the Department does not receive the missing or incomplete information within 10 calendar days after the date on the written notice, the Department shall consider the hospital's request withdrawn.
F. Before the end of the 30-day extension specified in subsection (C), a hospital administrator or designee may request an additional extension for submitting an annual financial statement and report of the audit of the annual financial statement by submitting a written request that:

1. Includes the information specified in subsections (C)(1) through (3)(3),
2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and report of the audit of the annual financial statement,
3. Is submitted to the Department at least 14 calendar days before the annual financial statement and report of the audit of the annual financial statement is due to the Department, and
4. Includes the reasons for the additional extension request.

G. In determining whether to approve or deny a request for a hospital to receive an additional extension as specified in subsection (F) for submitting an annual financial statement and report of the audit of the annual financial statement, the Department shall consider the following:

1. The reasons for the additional extension request provided according to subsection (F)(4);
2. The length of time for which the additional extension is being requested according to subsection (F)(2); and
3. If the hospital has a history of the following items:
   a. Repeated violations of the same statutes or rules,
   b. Patterns of noncompliance with statutes or rules,
   c. Types of violations of statutes or rules,
   d. Total number of violations of statutes or rules,
   e. Length of time during which violations of statutes or rules have been occurring, and
   f. Noncompliance with an agreement between the Department and the hospital.

H. The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and report of the audit of the annual financial statement within seven business days after receiving the request.

I. If the Department denies a request for an additional extension specified in subsection (F), a hospital may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

J. If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-203. Hospital Uniform Accounting Report

A. A hospital administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the hospital’s fiscal year.
B. A hospital administrator or designee shall submit a copy of the hospital’s Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospital;
2. The name, telephone number, and e-mail address of the:
   a. Hospital administrator,
   b. Hospital chief financial officer, and
   c. Individual who prepared the uniform accounting report;
3. The identification number assigned to the hospital:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the hospital’s national provider identifier;
4. The hospital’s classification;
5. Whether the entity that is the owner of the hospital is:
   a. Not for profit;
   b. For profit; or
   c. A federal, state, or local government agency;
6. Whether or not the hospital is Medicare-certified;
7. The ending date beginning and ending dates of the hospital’s reporting period;
8. If the hospital began operations during the hospital’s reporting period, the date on which the hospital began operations;
9. The date the uniform accounting report was submitted to the Department;
10. The licensed capacity, for each type of bed, at the end of the reporting period;
11. The licensed capacity at the end of the reporting period;
12. The number of available beds, for each type of bed, at the end of the reporting period;
13. The number of available beds at the end of the reporting period;
14. The number of admissions, for each type of bed, during the reporting period;
15. The total number of admissions during the reporting period;
16. The total number of patient days:
   a. During the reporting period, and
   b. For each type of bed during the reporting period;
17. The average occupancy rate for the reporting period;
18. The number of inpatient surgeries during the reporting period that required a patient to receive
inpatient services in the hospital;

19. The number of outpatient surgeries during the reporting period that did not require a patient to receive inpatient services in the hospital;

20. The number of births during the reporting period;

21. The number of nursery patient admissions during the reporting period;

22. The number of patient days for nursery patients during the reporting period;

23. The number of episodes of care during the reporting period provided by the:
   a. Emergency department,
   b. Urgent care unit, and
   c. Trauma center;

24. The total number of episodes of care during the reporting period provided by the emergency department, urgent care unit, or trauma center;

25. The number of episodes of care in the emergency department, urgent care unit, or trauma center during the reporting period for which the patient was subsequently admitted to the hospital;

26. The total number of FTEs at the end of the reporting period;

27. The turnover rate for the reporting period;

28. The vacancy rate for the reporting period;

29. The number of FTEs, for each type of employee, during the reporting period;

30. The vacancy rate, for each type of employee, for the reporting period;

31. The number of medical record coder FTEs during the reporting period;

32. The vacancy rate for medical record coders for the reporting period;

33. The number of medical record transcriptionist FTEs during the reporting period;

34. The vacancy rate for medical record transcriptionists for the reporting period;

35. For individuals who worked for the hospital as contracted workers during the reporting period, the number of hours worked by registered nurses;

36. The amount of revenue generated, for each type of revenue, by the hospital during the reporting period;

37. The amount of allowances given, for each type of allowance, by the hospital during the reporting period;

38. The total amount of revenue generated and allowances given by the hospital during the reporting period;

39. The operating expenses incurred, for each type of operating expense, by the hospital during the reporting period;

40. The total operating expenses incurred by the hospital during the reporting period;
41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospital during the reporting period;
43. The amount of assets, for each type of asset, of the hospital at the end of the reporting period;
44. The total amount of assets of the hospital at the end of the reporting period;
45. The amount of liabilities, for each type of liability, of the hospital at the end of the reporting period;
46. The total amount of liabilities of the hospital at the end of the reporting period;
47. The amount of net assets, for each type of net asset, of the hospital at the end of the reporting period;
48. The total amount of net assets of the hospital at the end of the reporting period;
49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and
50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3), unless the statement of cash flows has been submitted as part of the annual financial statement required in R9-11-202.

D. A hospital administrator or designee shall:
1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not complete;
      iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
      iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and
2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).
E. A hospital administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-205. Hospice Uniform Accounting Report

A. A hospice administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, within 150 calendar days after the end of the hospice’s fiscal year.

B. A hospice administrator or designee shall submit a copy of the hospice’s Medicare and Medicaid cost reports, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospice;
2. The identification number assigned to the hospice:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the hospice’s national provider identifier;
3. The beginning and ending dates of the hospice’s reporting period;
4. If the hospice began operations during the hospice’s reporting period, the date on which the hospice began operations;
5. The name, telephone number, and e-mail address of the:
   a. Hospice administrator,
   b. Hospice chief financial officer, and
   c. Individual who prepared the uniform accounting report;
6. The date the uniform accounting report was submitted to the Department;
7. Whether the hospice operates as a:
   a. Hospice service agency, or
   b. Hospice service agency with one or more hospice inpatient facilities;
8. Whether the entity that is the owner of the hospice is:
   a. Not for profit;
   b. For profit; or
c. A federal, state, or local government agency;

9. Whether or not the hospice is Medicare-certified;

10. The entity by which the hospice is accredited, if applicable;

11. Whether the hospice provides hospice services in an area that:
   a. Is equal to or more than two-thirds urban,
   b. Is equal to or more than two-thirds rural, or
   c. Is less than two-thirds urban and less than two-thirds rural;

12. Whether the hospice is:
   a. Free-standing,
   b. A hospital-based hospice,
   c. A nursing care institution-based hospice,
   d. An assisted living facility-based hospice, or
   e. A home health agency-based hospice;

13. If the hospice operates one or more hospice inpatient facilities, list for each hospice inpatient facility:
   a. The identification number assigned to the hospice inpatient facility by the Department;
   b. Whether the hospice inpatient facility is:
      i. Located within a hospital;
      ii. Located within a nursing care institution;
      iii. Located within an assisted living facility; or
      iv. Not located within a hospital, nursing care institution, or assisted living facility;
   e-b. The levels of care provided;
   d-e. The licensed capacity of the hospice inpatient facility;
   e-d. The total number of available beds at the beginning and end of the reporting period; and
   f-e. The average occupancy rate for the reporting period;

14. The number of patients during the reporting period that were:
   a. Referred to the hospice,
   b. Admitted to the hospice,
   c. Died while admitted to the hospice, and
   d. Discharged from the hospice while living;

15. The number of patient care days, for all patients, during the reporting period in which the hospice provided:
   a. Routine home care,
   b. Respite care services,
c. Continuous care, and  
d. Inpatient services;  
**16.15.** The total number of patient care days during the reporting period for all patients;  
**17.16.** The average daily census for the reporting period, calculated as the number specified in subsection (C)(16) (C)(15) divided by the number of days in the reporting period;  
**18.17.** Average length of stay, calculated as the number of patient care days for patients discharged during the reporting period divided by the sum of the numbers specified in subsections (C)(14)(e) (C)(13)(c) and (C)(14)(d) (C)(13)(d);  
**19.18.** Median length of stay for patients discharged during the reporting period;  
**20.19.** The number of patients admitted to the hospice during the reporting period:  
   a. By gender;  
   b. By age group;  
   c. By race and ethnicity;  
   d. From:  
   i. A private home owned or leased by, or on behalf of, a patient;  
   ii. An assisted living facility;  
   iii. A nursing care institution;  
   iv. A hospital; and  
   v. A hospice;  
   e. With a principal diagnosis of:  
   i. Cancer,  
   ii. Heart disease,  
   iii. Dementia,  
   iv. Lung disease,  
   v. Kidney disease,  
   vi. Stroke or coma,  
   vii. Liver disease,  
   viii. HIV-related disease,  
   ix. Motor neuron disorder,  
   x. Unspecified debility, and  
   xi. A disease not specified in subsections (C)(20)(e)(i) (C)(19)(e)(i) through (C)(20)(e)(x) (C)(19)(e)(x); and  
   f. Whose payer source is:  
   i. Medicare,
ii. AHCCCS,  
iii. Self-pay,  
iv. A private insurance company, and  
v. A payer source not specified in subsections (C)(20)(f)(i) through (C)(20)(f)(iv) (C)(19)(f)(iv);  

21/20. The total number of patient care days during the reporting period that the hospice provided hospice services to a patient whose principal diagnosis was related to:  
   a. Cancer,  
   b. Heart disease,  
   c. Dementia,  
   d. Lung disease,  
   e. Kidney disease,  
   f. Stroke or Coma,  
   g. Liver disease,  
   h. HIV-related disease,  
   i. Motor neuron disorder,  
   j. Unspecified debility, and  
   k. Any other disease not specified in subsections (C)(21)(a) through (C)(20)(j);  

22/21. The number of FTEs providing hospice services, for each type of employee, during the reporting period;  

23/22. The total number of FTEs providing hospice services during the reporting period;  

24/23. The average caseload during the reporting period for a licensed nurse, calculated as the total number of patients assigned to licensed nurses working for the hospice during the reporting period, divided by the total number of licensed nurses working for the hospice during the reporting period, for:  
   a. Outpatient hospice services, and  
   b. Hospice services provided in hospice inpatient facilities;  

25/24. The average caseload during the reporting period for a social worker, calculated as the total number of patients assigned to social workers working for the hospice during the reporting period, divided by the total number of social workers working for the hospice during the reporting period, for:  
   a. Outpatient hospice services, and  
   b. Hospice services provided in hospice inpatient facilities;  

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26.25. The average caseload during the reporting period for nursing personnel other than a licensed nurse, calculated as the total number of patients assigned to nursing personnel other than licensed nurses working for the hospice during the reporting period, divided by the total number of nursing personnel other than licensed nurses working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
   b. Hospice services provided in hospice inpatient facilities;

27.26. The average caseload during the reporting period for a chaplain, calculated as the total number of patients assigned to chaplains working for the hospice during the reporting period, divided by the total number of chaplains working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
   b. Hospice services provided in hospice inpatient facilities;

28.27. The number of individuals who received bereavement services from the hospice during the reporting period;

29.28. The number of individuals from the hospice who provided bereavement services during the reporting period;

30.29. The total number of volunteers during the reporting period;

31.30. The total number of hours that volunteers provided hospice services during the reporting period;

32.31. The number of patient care days during the reporting period, for whom:
   a. The payer source was:
      i. Medicare,
      ii. AHCCCS,
      iii. Self-pay,
      iv. A private insurance company, and
      v. A payer source not specified in subsections (C)(32)(a)(i) (C)(31)(a)(i) through (C)(32)(a)(iv) (C)(31)(a)(iv), and
   b. There was no payer source identified;

33.32. The total number of patient care days specified in subsections (C)(32) subsection (C)(31);

34.33. The total amount of money billed, during the reporting period to:
   a. Medicare,
   b. AHCCCS,
   c. Self-pay,
   d. A private insurance company, and
   e. A payer source not specified in subsections (C)(34)(a) (C)(33)(a) through (C)(34)(d) (C)(33)(d);
35. The total amount of money billed during the reporting period;
36. The amount of revenue generated, for each type of revenue, by the hospice during the reporting period;
37. The amount of allowances given, for each type of allowance, by the hospice during the reporting period;
38. The total amount of revenue generated and allowances given by the hospice during the reporting period;
39. The operating expenses incurred, for each type of operating expense, by the hospice during the reporting period;
40. The total operating expenses incurred by the hospice during the reporting period;
41. The difference between the amount identified in subsection (C)(38) (C)(37) and the amount identified in subsection (C)(40) (C)(39);
42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospice during the reporting period;
43. The amount of assets, for each type of asset, of the hospice at the end of the reporting period;
44. The total amount of assets of the hospice at the end of the reporting period;
45. The amount of liabilities, for each type of liability, of the hospice at the end of the reporting period;
46. The total amount of liabilities of the hospice at the end of the reporting period;
47. The amount of net assets, for each type of net asset, of the hospice at the end of the reporting period;
48. The total amount of net assets of the hospice at the end of the reporting period;
49. The difference between the amount identified in subsection (C)(48) (C)(47) and the amount identified in subsection (C)(46) (C)(45); and
50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3).

D. A hospice administrator or designee shall:
1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the hospice administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not
iii. State what actions the hospice is taking to correct the inaccurate information or make the information complete; and

iv. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospice administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospice administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.
ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. Definitions
In this Article, unless otherwise specified:

1. “Adolescent” means an individual the hospital designates as an adolescent based on the hospital’s criteria.
2. “Adult” means the same as in A.A.C. R9-10-201.
4. “Blood bank cross match” means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
5. “Complete blood count with differential” means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual’s blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
6. “Contrast medium” means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
7. “CT” means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.
8. “Current rates and charges information” means the most recent rates and charges schedule for a health care institution on file with the Department, and all documents changing the most recent rates and charges schedule.
10. “EEG” means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.
11. “EKG” means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. “Facility” means a building and associated personnel and equipment that perform a particular service or activity.
13. “Formulary” means a list of drugs that are available to a patient through a hospital.
15. “Home health agency administrator” means the chief administrative officer for a home health agency.
16. “Hospital department” means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. “Implementation date” means the month, day, and year a health care institution intends to begin using specific rates and charges when billing a patient or resident.
18. “Intensive care bed” means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. “IVP” means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. “Labor and delivery” means services provided to a woman related to childbirth.
21. “Lithotripsy” means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. “Mark-up” means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. “MRI” means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. “Neonate” means the same as in A.A.C. R9-10-201.
25. “Nursery bed” means an available bed used to provide hospital services to a neonate.
27. “Outpatient treatment center administrator” means the chief administrative officer for an outpatient treatment center.
28. “Overview form” means a document:
   a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital’s current rates and charges information, and
   b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. “Pediatric” means the same as in A.A.C. R9-10-201.
30. “Pediatric bed” means an available bed used to provide hospital services to a pediatric patient.
32. “Post-hospital extended care services” means the services that are described in and meet the requirements of 42 CFR 409.31.
33. “Private room” means a room that contains one available bed.
34. “Rate” means a specific dollar amount per unit of service set by a health care institution.
35. “Rates and charges schedule” means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.
36. “Rehabilitation bed” means a type of bed used to provide services to a patient to restore or to
optimize the patient’s functional capability.

37. “Review” means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.

38. “Semi-private room” means a room that contains two available beds.

39. “Skilled nursing bed” means an available bed used for a patient requiring skilled nursing services.

40. “Skilled nursing services” means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.

41. “Small volume nebulizer” means a device that:
   a. Holds liquid medicine that is turned into a mist by an air compressor, and
   b. Is used for treatments lasting less than 20 minutes.

42. “Swing bed” means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.

43. “Swing-bed hospital” means the same as in 42 CFR 413.114.

44. “Trauma team activation” means a notification by a health care institution:
   a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;
   b. That is based on a patient’s triage information; and
   c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.

45. “Ultrasound” means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.
ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING

R9-11-402. Reporting Requirements

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department with the inpatient discharge report required in subsection (C):
   1. The name of the hospital;
   2. The hospital’s Arizona facility ID and national provider identifier;
   3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the inpatient discharge report;
   4. If the entity submitting the inpatient discharge report to the Department is different from the hospital:
      a. The name of the entity submitting the inpatient discharge report to the Department; and
      b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the inpatient discharge report;
   5. The reporting period; and
   6. The name of the electronic file containing the inpatient discharge report specified in subsection (C).

B. A hospital administrator or designee shall on a form provided by the Department:
   1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
   2. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
      a. Identify the information that is not accurate or not complete;
      b. Describe the circumstances that make the information not accurate or not complete;
      c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
      d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.

C. A hospital administrator shall ensure that an inpatient discharge report:
   1. Is prepared and named in a format specified by the Department;
   2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
   3. Contains the following information for each inpatient discharge that occurred during the reporting
period specified in subsection (A)(5):

a. The Arizona facility ID and national provider identifier for the hospital;

b. A code indicating that the information submitted about the patient is for an inpatient episode of care;

c. The patient’s medical record number;

d. The patient’s control number;

e. The patient’s name;

f. The patient’s mailing address;

g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;

h. A code indicating that the patient is homeless, if applicable;

i. The patient’s date of birth and last four digits of the patient’s Social Security number;

j. Codes indicating the patient’s gender, race, ethnicity, and marital status;

k. The date and a code indicating the hour the patient was admitted to the hospital;

l. A code indicating the priority of visit;

m. A code indicating the referral source;

n. The date and a code indicating the hour the patient was discharged from the hospital;

o. A code indicating the patient’s discharge status;

p. If the patient is a newborn, the patient’s birth weight in grams;

q. Whether the patient has a DNR known to the hospital;

r. The date the bill for hospital services was created;

s. The total charges billed for the episode of care;

t. A code indicating the expected payer source;

u. For each unit of service billed for the episode of care, the:

i. Revenue code;

ii. Charge billed; and

iii. HIPPS code, if applicable;

v. The DRG code for the episode of care;

w. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;

x. The International Classification of Diseases codes for the patient’s admitting, principal, and secondary diagnoses;

y. If applicable, the E-codes external cause of injury codes or location of injury codes associated with the episode of care;
z. If applicable, the state in which an accident leading to the episode of care occurred;
aa. If applicable, the date of the onset of symptoms leading to the episode of care;
bb. If a procedure was performed during the episode of care:
   i. The International Classification of Diseases codes for the principal procedure and any other procedures performed during the episode of care, and
   ii. The dates the principal procedure and any other procedures were performed;
cc. The name, state license number, and, if applicable, national provider identifier of the patient’s attending provider;
dd. The code for the state licensing board that issued the license for the patient’s attending provider;
ee. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient’s principal procedure, if applicable;
ff. The code for the state licensing board that issued the license for the medical practitioner who performed the patient’s principal procedure, if applicable;
gg. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient’s episode of care; and
hh. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(gg).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department at least twice each calendar year, according to the following schedule:
   1. For initial electronic submission of reports for individual inpatient discharges on a real-time basis, within 48 hours after the discharge; and
   2. For bulk submission of inpatient discharges or completion of an electronic submission:
      1-a. For each inpatient discharge between January 1 and June 30, the reports, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
      2-b. For each inpatient discharge between July 1 and December 31, the reports, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of a report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:
   1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.
ARTICLE 5. EMERGENCY DEPARTMENT DISCHARGE REPORTING

R9-11-502. Reporting Requirements

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department as part of the emergency department discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital’s Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the emergency department discharge report;
4. If the entity submitting the emergency department discharge report to the Department is different from the hospital:
   a. The name of the entity submitting the emergency department discharge report to the Department; and
   b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the emergency department discharge report;
5. The reporting period; and
6. The name of the electronic file containing the emergency department discharge report specified in subsection (C).

B. A hospital administrator or designee shall on a form provided by the Department:

1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
2. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
   a. Identify the information that is not accurate or not complete;
   b. Describe the circumstances that make the information not accurate or not complete;
   c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
   d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.

C. A hospital administrator shall ensure that an emergency department discharge report:

1. Is prepared and named in a format specified by the Department;
2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and

3. Contains the following information for each emergency department discharge that occurred during the reporting period specified in subsection (A)(5):
   a. The Arizona facility ID and national provider identifier for the hospital;
   b. A code indicating that the information submitted about the patient is for an emergency department episode of care;
   c. The patient’s medical record number;
   d. The patient’s control number;
   e. The patient’s name;
   f. The patient’s mailing address;
   g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
   h. A code indicating that the patient is homeless, if applicable;
   i. The patient’s date of birth and last four digits of the patient’s Social Security number;
   j. Codes indicating the patient’s gender, race, ethnicity, and marital status;
   k. The date and a code indicating the hour the episode of care began;
   l. A code indicating the priority of visit;
   m. A code indicating the referral source;
   n. The date and a code indicating the hour the patient was discharged from the emergency department;
   o. A code indicating the patient’s discharge status;
   p. Whether the patient has a DNR known to the hospital;
   q. The date the patient’s bill was created;
   r. The total charges billed for the episode of care;
   s. A code indicating the expected payer source;
   t. For each unit of service billed for the episode of care, the:
      i. Revenue code;
      ii. Charge billed; and
      iii. HCPCS code, if applicable;
   u. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;
   v. The International Classification of Diseases code designating the reason for the patient initiating the episode of care;
w. The International Classification of Diseases codes for the patient’s principal and, if applicable, secondary diagnoses;

x. If applicable, the E-codes external cause of injury codes or location of injury codes associated with the episode of care;

y. If applicable, the state in which an accident leading to the episode of care occurred;

z. If applicable, the date of the onset of symptoms leading to the episode of care;

aa. For each procedure performed during the episode of care:
   i. The applicable International Classification of Diseases, HCPCS/CPT codes for the principal procedure and any other procedures performed during the episode of care; and
   ii. The dates the principal procedure and any other procedures were performed;

bb. The name, state license number, and, if applicable, national provider identifier of the patient’s attending provider;

c. The code for the state licensing board that issued the license for the patient’s attending provider;

dd. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient’s principal procedure, if applicable;

e. The code for the state licensing board that issued the license for the medical practitioner who performed the patient’s principal procedure, if applicable;

ff. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient’s episode of care; and

g. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(ff).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department at least twice each calendar year, according to the following schedule:

1. For initial electronic submission of reports for individual emergency department discharges on a real-time basis, within 48 hours after the discharge; and

2. For bulk submission of emergency department discharges or completion of an electronic submission:
   2-a. For each emergency department discharge between January 1 and June 30, the report, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
   2-b. For each emergency department discharge between July 1 and December 31, the report,
information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of an emergency department discharge report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.
ARTICLE 6. HEALTH PROFESSIONALS WORKFORCE DATABASE

R9-11-601. Definitions
In addition to the definitions in A.R.S. § 32-3249 and R9-11-101, the following definitions apply in this Article unless otherwise specified:

2. “Primary practice location” means the facility in which an individual provides direct patient care for the majority of time during a year.

R9-11-602. Designated Database Information
A. A Board shall establish a process for requesting the information in subsection (B):
   1. From an individual applying for an initial license, certification, or registration, at the time of application; and
   2. From an individual regulated by the Board, in compliance with A.R.S. § 32-3249.01(A).

B. A Board shall request the following information about an individual, in a Department-provided format:
   1. The individual’s name;
   2. The individual’s date of birth;
   3. The individual’s gender;
   4. The individual’s race and ethnicity;
   5. If applicable, the individual’s National Provider Number;
   6. Whether the individual is able to provide services to patients or clients in a language other than English and, if so, in which languages;
   7. The type of license, certification, or registration held by the individual or for which the individual is applying;
   8. The individual’s professional license, registration, or certification number, if applicable;
   9. The beginning and end date of the individual’s current license, certification, or registration, if applicable;
   10. The individual’s highest level of training or education related to the individual’s license, certification, or registration;
   11. The individual’s highest level of education in another field;
   12. The individual’s current employment status;
   13. Whether the individual is currently providing direct patient care related to the individual’s license, certification, or registration, as applicable, on a regular basis in Arizona and, if so:
      a. The zip code of the individual’s primary practice location;
      b. The type of facility in which the individual is providing direct patient care at the primary
c. The number of weeks worked over the previous 12 months at the primary practice location;

d. The average hours worked per week at the primary practice location, including the percentage of time spent in:
   i. Direct patient care;
   ii. Administration, including any paperwork not part of direct patient care;
   iii. Research;
   iv. Teaching or education; or
   v. Other specified activities;

e. Whether the individual expects a change in subsection (B)(13)(b), (c), or (d) in the next 12 months; and

f. If the individual expects to reduce the time spent providing direct patient care in the next 12 months, the reason for the change; and

14. If the individual is a physician, physician assistant, or registered nurse practitioner, whether the individual provides primary care services, as defined in A.A.C. R9-24-201.

R9-11-603. Transfer of Data from a Board

A. A Board shall transfer the designated database information collected according to R9-11-602 to the Department:

1. Within 60 calendar days after the effective date of this Section and on or before April 30 each year thereafter;

2. In a secure format specified by the Department and agreed to by the Board and the Department, based on the capabilities and limitations of the Board’s data system that is used for storing the collected designated database information; and

3. Without the Board needing to change the format of the designated database information in the Board’s data system.

B. For an initial transfer of designated database information each year, a Board shall transfer to the Department:

1. The designated database information specified in R9-11-602(B) that is already collected by the Board as part of the Board’s licensing, certification, or registration process; and

2. Any other collected designated database information specified in R9-11-602, even if the information is incomplete.

C. The Department shall:

1. Review the designated database information transmitted by each Board according to subsection
(B) for completeness and consistency with the designated database information specified in R9-11-602(B)(1) through (13) and, if applicable, R9-11-602(B)(14);

2. Notify each Board of:
   a. Inconsistencies with the designated database information specified in R9-11-602(B)(1) through (14), and
   b. Incomplete information about individuals regulated by the Board;

3. Compile the designated database information transmitted by each Board into a single data set, stored in the health care professionals workforce data repository specified in A.R.S. § 36-171(A); and

4. Post the availability of designated database information on the Department’s website.

D. Based on the information provided by the Department according to subsection (C)(2), a Board shall each year:
   1. Review the process established by the Board according to R9-11-602(A), and
   2. Make changes to the process that improve the consistency and completeness of the designated database information that will be transferred to the Department in the subsequent year.

R9-11-604. Requests for Release of Designated Database Information and Reports

A. Designated database information is confidential, subject to the disclosure provisions of A.R.S. § 32-3249.01(B) and (C) and 9 A.A.C. 1, Article 3.

B. The Department:
   1. Shall release designated database information in an annual data set;
   2. May release designated database information in a customized data set; and
   3. May release reports summarizing the designated database information, based upon information requested.

C. A person may request the release of designated database information by submitting to the Department:
   1. A written request, in a Department-provided format, that includes:
      a. The name, mailing address, email address, and telephone number of the person submitting the request;
      b. If applicable, the name, title, email address, and telephone number of an individual from an organization specified according to subsection (C)(1)(a);
      c. The address to which released designated database information is to be sent;
      d. In which of the Department-specified, secure formats the person is requesting the released designated database information to be sent;
      e. If requesting the release of designated database information in a customized data set according to subsection (B)(2), the specific designated database information being
requested, including:

i. The specific Board or Boards,

ii. The time period for the requested designated database information, and

iii. Any other descriptors for the requested designated database information;

f. The reason the person is requesting the release of designated database information;

g. A description of the methods to be used by the person to ensure the privacy and security of released designated database information;

h. Attestations that the person requesting the release of designated database information:

i. Shall not use or disclose any portion of the released designated database information for any purpose other than a purpose specified according to subsection (C)(1)(f);

ii. Shall safeguard the released designated database information from unauthorized access, including ensuring that the designated database information is not re-released to another person;

iii. Shall not attempt to reidentify or contact individuals based on released designated database information;

iv. Shall notify the Department upon learning the identity of an individual in the released designated database information;

v. Understands that failure to ensure the privacy and security of released designated database information may result in denial of future releases of designated database information;

vi. Understands that the Department retains ownership of the released designated database information;

vii. Shall retain designated database information for a period of no more than five years from the date of release; and

viii. Shall submit a certificate of destruction, in a Department-provided format, to the Department upon destruction of the released designated database information;

i. The dated signature of the individual specified according to subsection (C)(1)(b); and

2. Either:

a. A fee of $100 for the release of designated database information in an annual data set, or

b. A fee that covers the costs of the Department in producing and releasing designated database information in a customized data set.

D. A person may request the release of a report summarizing the designated database information or specific
portions of the designated database information by submitting to the Department:

1. A written request, in a Department-provided format, that includes:
   a. The name, mailing address, email address, and telephone number of the person submitting the request;
   b. If applicable, the name, title, email address, and telephone number of an individual from an organization specified according to subsection (C)(1)(a);
   c. The address to which the released report is to be sent;
   d. The specific designated database information to be included in the summarized report, including:
      i. The specific Board or Boards,
      ii. The time period of the requested designated database information, and
      iii. Any other descriptors of the requested designated database information; and
   e. The dated signature of the individual specified according to subsection (D)(1)(b); and

2. A fee that covers the costs of the Department in producing and releasing the report.
TITLE 9. HEALTH SERVICES

CHAPTER 11. HEALTH CARE INSTITUTION FACILITY AND HEALTH PROFESSIONALS WORKFORCE DATA

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

June 2022
1. **An identification of the rulemaking**

   Laws 2018, Ch. 293, amended Arizona Revised Statutes (A.R.S.) § 36-104 to require the Arizona Department of Health Services (Department) to adopt rules “prescribing the designated database information to be collected by health professional regulatory boards” pursuant to A.R.S. Title 32, Chapter 32, Article 5. Laws 2019, Ch. 215, added A.R.S. § 36-171 to require the Department to adopt rules to establish and maintain the health professionals workforce data repository containing the designated database information collected and transferred to the Department pursuant to Title 32, Chapter 32, Article 5. The Department is adopting these rules in Arizona Administrative Code (A.A.C.) Title 9, Chapter 11, consistent with recommendations of the Health Care Professionals Workforce Data Repository Advisory Committee. Currently, in Articles 2 through 5 of 9 A.A.C. 11 are rules implementing A.R.S. §§ 36-125.04, 36-125.05, 36-436 through 36-436.03, and 36-2901.08, related to the reporting of data about health care institutions. As part of a five-year-review report, the Department has identified several changes to these rules that would improve the rules, make them more effective, and reduce the burden on reporting health care institutions. After receiving an exception from the rulemaking moratorium established by Executive Order 2019-01, the Department is adopting rules to comply with Laws 2018, Ch. 293, and Laws 2019, Ch. 215, and making changes to the existing Articles in the Chapter as identified in the five-year-review report.

2. **Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rules**

   - The Department
   - The Boards, as defined in A.R.S. § 32-3249
   - Requesters of designated database information and summary reports
   - Individuals applying to or regulated by a Board
   - General public

3. **Cost/Benefit Analysis**

   This analysis covers costs and benefits associated with the rule changes. Up to one new FTEs will be required due to this rulemaking, as described below. This rulemaking establishes a new fee, authorized by A.R.S. § 36-171(C)(4). Annual costs/revenues are designated as minimal when
more than $0 and $1,000 or less, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification.

<table>
<thead>
<tr>
<th>Description of Affected Groups</th>
<th>Description of Effect</th>
<th>Increased Cost/ Decreased Revenue</th>
<th>Decreased Cost/ Increased Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. State and Local Government Agencies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Making the rules in Articles 1 through 5 clearer and easier to understand Setting up and implementing a health professionals workforce data repository Preparing and providing designated database information and summary reports to requesters</td>
<td>None</td>
<td>Significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substantial</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substantial</td>
<td>Substantial</td>
</tr>
<tr>
<td>Boards, as defined in A.R.S. § 32-3249</td>
<td>Requesting, storing, and transferring to the Department the indicated information</td>
<td>Substantial</td>
<td>None</td>
</tr>
<tr>
<td>Local governments</td>
<td>Having access to information contained in the health professionals workforce data repository</td>
<td>Minimal</td>
<td>Significant</td>
</tr>
<tr>
<td><strong>B. Privately Owned Businesses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care institutions</td>
<td>Making the rules in Articles 1 through 5 clearer and easier to understand</td>
<td>None</td>
<td>Significant</td>
</tr>
<tr>
<td>Requesters of designated database information and summary reports</td>
<td>Having access to information contained in the health professionals workforce data repository</td>
<td>Minimal-to-moderate</td>
<td>Significant</td>
</tr>
<tr>
<td><strong>C. Consumers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals applying to or regulated by a Board</td>
<td>Providing information to a Board for transfer to the Department</td>
<td>Minimal</td>
<td>Significant</td>
</tr>
<tr>
<td>General public</td>
<td>Increasing the information upon which persons may make decisions related to the locations and staffing of health care institutions</td>
<td>None</td>
<td>Significant</td>
</tr>
</tbody>
</table>

- **The Department**
  A number of issues in Articles 1 through 5 of the Chapter were identified as part of the five-year review of the rules in 2020. Those issues that would not require a statutory change are addressed as part of the rulemaking. These include revising the definitions of “discharge status”
and “inpatient,” clarifying the classifications of health care institutions, and replacing terms specific to the obsolete ICD-CM-9 billing codes with more generic terms for the same concept. The Department believes that these changes may reduce confusion on the part of reporting entities and reduce the time Department staff spend clarifying what is meant and what should be reported to the Department. The Department anticipates these changes may provide a significant benefit to the Department.

The new rules in 9 A.A.C. 11, Article 6, are being adopted to comply with Laws 2018, Ch. 293 and Laws 2019, Ch. 215, which added A.R.S. § 36-171 to require the Department to adopt rules to establish and maintain the health professionals workforce data repository containing the designated database information collected and transferred to the Department pursuant to Title 32, Chapter 32, Article 5. In setting up and implementing a health professionals workforce data repository, the Department followed the recommendations of the advisory committee established according to A.R.S. § 36-173, which recommended that the Department:

- Align, to the extent possible, current questions, and information already being collected by each Board to avoid duplication;
- Allow each Board the ability to collect/utilize profession-specific information in the data fields collected by each board;
- Make clear that professional boards may collect any additional information they deem necessary or important;
- Use categories for race, gender, and ethnicity that adhere to those in use by Centers for Medicare and Medicaid Services (CMS) or other federal agencies;
- Require a basic data set established by the rules to be requested;
- Collect data, to the extent possible, for each profession’s practice setting (e.g. hospitals, outpatient treatment center, private practices, etc.);
- Allow each Board flexibility in the specialty designations, practice settings, and information unique to the profession data fields collected from each licensee, while requiring data collection of data within those fields in a standardized manner (no free text fields) to the extent possible;
- Require submission of data at least once each year; and
- Provide data to requestors based on a complete calendar year.

The Department worked closely with the Boards affected by the legislation to determine what data was already being collected by the Boards; the frequency, timing, and method of data collection; how the data were currently being collected and stored; and how data could best be transferred to the Department to reduce the burden on the Boards. To meet the statutory
requirements, the Department is establishing a permanent repository that will house the annual data sets in perpetuity. The Department anticipates that at least 150,000 data records will be transferred to the Department annually. The Department estimates that the Department incurred approximately $100,000 in costs for these activities. However, these costs are the result of the statutory changes, rather than the rules.

Once the Boards have transferred the designated database information to the Department according to R9-11-603(A) and (B) and the Department has completed the activities in R9-11-603(C), the Department must prepare designated database information into an annual data set. The Department estimates that it may require at least one FTE working in conjunction with information technology database administrators at least six months to create the annual data set. Thus, the Department’s costs to produce the annual data set are expected to be substantial. Although the Department cannot accurately estimate how many requests there will be for the annual data set, at $100 per request, the Department believes that the Department may receive up to a substantial benefit from the release of the annual data set to requesters.

In addition, the Department anticipates that some requestors will want a customized data set, tailored to their specific needs. The costs to create these data sets will vary, depending on the complexity of the request and the amount of data manipulation it will take to obtain the information requested. Other requesters may not have the time or expertise to analyze raw designated database information and may want the Department to create reports summarizing the data. Again, the costs to create these summary reports will vary depending on what is requested. The rules specify in R9-11-604(C)(2)(b) and (D)(2) that the fee for a customized data set or a report summarizing the data will be determined based on the costs to the Department in producing the reports, which are expected to be minimal for each report but may be up to substantial in the aggregate for both costs and benefits.

- **Boards, as defined in A.R.S. § 32-3249**

  The health profession regulatory boards affected by these rules include the Arizona Medical Board, Board of Nursing, Arizona Board of Osteopathic Examiners in Medicine and Surgery, Board of Physical Therapy, Board of Psychologist Examiners, and Board of Behavioral Health Examiners. These six Boards use four separate data systems for storing their data, and the Department will be collecting data from all four. The Arizona Medical Board and Arizona Board of Osteopathic Examiners in Medicine and Surgery share a common data system maintained by a third party but house their data themselves. The Board of Nursing uses a national system hosted by a national nursing organization over which they have limited control. The Board of Physical Therapy and Board of Psychologist Examiners both use the E-Certify system (salesforce) hosted
at the Arizona Department of Administration (ADOA). The Board of Behavioral Health Examiners has no system at all, hosting their data in a home-grown Microsoft Access database.

At the time the rules were being developed, the Board collecting most of the information specified in the rules was the Board of Physical Therapy, which stated that they had already implemented most of the proposed data elements into their e-Certify build at ADOA, and thought that it would be relatively easy for ADOA to make that development coding available to the Board of Psychologist Examiners. Of the remaining boards, the Board of Nursing seemed to have more of the listed data elements than most of the others, but didn't have them all. The Board of Behavioral Health Examiners had the least. The Department has maintained contact with each Board throughout the rulemaking process, including setting up some Boards with electronic access to the Department’s secure file transfer protocol (SFTP) server, which will be used for data transfers. The Department has repeatedly made efforts to gather data structure shells from each Board for the purpose of establishing processes to standardize the datasets and create the annual dataset. However, such data structure shells have not provided by every Board. The Boards have indicated that they will not transfer data until the rules go into effect. Because half of the Boards use systems not under their direct control and would require the data systems to be customized by a third party, changes to include all data elements could take a long period of time and be quite costly.

The Department anticipates that requesting, storing, and transferring to the Department the indicated information may result in a substantial cost to a Board, the bulk of which is due to statutory requirements rather than the rules. The Department has included in the rules provisions to minimize or mitigate these costs. Because of the differences in data systems, plans for collection of data, and licensing periods, the rules allow the Boards flexibility for when and how a Board would request the specified information. Each Board is required by R9-11-602(A) to establish a process for requesting the specified information and is allowed by R9-11-603(A)(3) to transfer the information to the Department without needing to change the format of the designated database information in the Board’s data system. According to R9-11-603(B), the initial transfer is required to include the specified information that is already being collected by the Board for its regulatory purposes and any other collected designated database information, even if the information is incomplete. To ensure that complete data is eventually transferred and available under the requirements in R9-11-604, a Board is required under R9-11-603(D) to review and make changes to the process each year to improve the consistency and completeness of the designated database information that will be transferred to the Department in the subsequent year.

- **Health care institutions**
The rules currently in 9 A.A.C. 11 implement several statutes related to the reporting of data about health care institutions. Article 2 of 9 A.A.C. 11 implements A.R.S. §§ 36-125.04 and 36-2901.08 by providing requirements for hospitals, nursing care institutions, and hospices to follow when submitting annual financial statements or uniform accounting reports to the Department. The rules in 9 A.A.C. 11, Article 3, implement A.R.S. §§ 36-436 through 36-436.03 by providing requirements for hospitals, nursing care institutions, home health agencies, and outpatient treatment centers to submit schedules of rates and charges or changes to the schedules. The rules in 9 A.A.C. 11, Articles 4 and 5, implement A.R.S. § 36-125.05 by providing requirements for submitting hospital discharge data. The Department had identified, as part of a five-year-review report, changes that should be made to these rules. These changes include clarifying several rules in Article 2, replacing a term specific to the obsolete ICD-CM-9 coding system, making provisions for a future real-time submission of hospital discharge data, and correcting cross-references to defined terms. The Department believes that these changes may improve the rules, make them more effective, and reduce the burden on reporting health care institutions, thus, providing a significant benefit to a reporting health care institution.

- **Requesters of designated database information and summary reports, including local governments**

  City planners and/or local governments require data upon which to make decisions that affect the areas under their jurisdictions. Zoning or rezoning decisions, decisions on whether or not to approve a variance, negotiating contracts with ambulance services, and many other tasks, situations, and events may require a city planner or local government to be aware of the number, types, and distribution of health professionals within the jurisdiction. Chambers of Commerce and regional economic development associations, such as Westmarc and East Valley Partnership, may also find this information useful. Commercial real estate developers, especially those interested in future zoning strategy for healthcare facilities, could also benefit from the availability of designated database information. Currently, this information may be difficult and costly to obtain.

  Other groups may find information about the number, types, and distribution of health professionals useful in achieving their various goals. Non-profit organizations that may be interested in designated database information include foundations interested in healthcare, mental health, and economic development; advocacy groups focused on access to care; and Community Development Financial Institutions (CDFIs) that support infrastructure development in underserved areas. These organizations could benefit from knowing in what geographic areas there is a shortage (or surplus) of health professionals so as to better focus their efforts. Similarly, individual hospitals, healthcare systems, and other health care institutions may find designated
database information helpful, especially if interested in siting new facilities or altering existing staffing models. Professional associations, such as associations representing these entities or health professionals, would also be interested in designated database information, as would health insurers, including those thinking about entering into new markets and actuaries who set reimbursement amounts.

Finally, there are other groups that may use information from the health professionals workforce data repository for research purposes or to support suppositions or theories. These include researchers in universities or community colleges, as well as representatives of media outlets seeking information about a story they are developing. Gathering such data de novo would be difficult and time-consuming, as well as being potentially inaccurate. Obtaining the data from a Board or similar data through independent sources might also be costly.

These rules will have the effect of creating the health professionals workforce data repository, as required by Laws 2018, Ch. 293 and Laws 2019, Ch. 215, containing the designated database information collected and transferred to the Department pursuant to Title 32, Chapter 32, Article 5. The Department compiles the information and makes the designated database information available in an annual data set. For those who need specific data, customized data sets may be released. For those without the ability to analyze the data themselves, reports summarizing the designated database information may also be available. The Department anticipates that increasing the availability of information upon which persons may make decisions related to the locations and staffing of health care institutions may provide a significant benefit to those requesting designated database information and summary reports. Those persons requesting designated database information and summary reports may incur as much as a moderate cost for the information or report, but the amount of these costs is at the discretion of the requester.

- **Individuals applying to or regulated by a Board**

As mentioned above, the Boards to which these rules apply are the Arizona Medical Board, Board of Nursing, Arizona Board of Osteopathic Examiners in Medicine and Surgery, Board of Physical Therapy, Board of Psychologist Examiners, and Board of Behavioral Health Examiners. Under the rules, individuals applying to or regulated by one of these Boards are subject to the Board’s request for the information specified in R9-11-602(B) at the time of initial application or renewal. Much of the information being requested is already being required by some of the Boards. If a Board collected none of the information specified in R9-11-602(B) as part of its regulatory function, the Department estimates that an individual responding to the Board’s request for this information would incur minimal costs for the time they spend providing the
information. These individuals may also receive a significant benefit from actions taken by a requestor of designated database information based on the information received.

- **General public**

As mentioned above, many different types of persons may find a use for designated database information and request this data from the Department. Increasing the information upon which these persons may make decisions related to the locations and staffing of health care institutions may increase the quality or availability of health care in different areas of the State. As such, the Department anticipates that the rules may provide a significant benefit to the general public.

4. **A general description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking**

5. **A statement of the probable impact of the rules on small business**
   a. **Identification of the small businesses subject to the rules**
      Small businesses subject to the rules may include small health care institutions.
   b. **The administrative and other costs required for compliance with the rules**
      Anticipated costs for complying with the rules are described under paragraph 3.
   c. **A description of the methods that the agency may use to reduce the impact on small businesses**
      The Department is unaware of any measures that may be taken to reduce the impact on small businesses while still protecting the health and safety of the citizens of Arizona.
   d. **The probable costs and benefits to private persons and consumers who are directly affected by the rules**
      The costs to private persons and consumers from the rulemaking are described in paragraph 3.

6. **A statement of the probable effect on state revenues**

The rulemaking includes fees for designated database information and summary reports. According to A.R.S. § 36-172, these funds, as well as legislative appropriations, private gifts, grants, donations, and contributions, are deposited into the workforce data repository fund. The monies in this fund do not revert to the state general fund, so this rulemaking should not affect state revenues.

7. **A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking**

There are no less intrusive or less costly alternatives for achieving the purpose of the rule.
8. A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data

Not applicable
ARTICLE 1. DEFINITIONS

Section
R9-11-101. Definitions
R9-11-102. Recodified
R9-11-103. Recodified
R9-11-104. Recodified
R9-11-105. Recodified
R9-11-106. Recodified
R9-11-107. Recodified
R9-11-108. Recodified
R9-11-109. Recodified
R9-11-110. Repealed
R9-11-111. Repealed
R9-11-112. Repealed
R9-11-113. Repealed
R9-11-114. Repealed
R9-11-115. Repealed
R9-11-116. Repealed
R9-11-117. Repealed
R9-11-118. Repealed
R9-11-119. Repealed
R9-11-120. Repealed
R9-11-121. Repealed
ARTICLE 3. RATES AND CHARGES SCHEDULES

Article 3, consisting of Section R9-11-301 and R9-11-302, adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1).

Section
R9-11-301. Definitions
R9-11-302. Hospital Rates and Charges Schedule
Table 1. Recodified
R9-11-303. Nursing Care Institution Rates and Charges Schedule
R9-11-304. Home Health Agency Rates and Charges Schedule
R9-11-305. Outpatient Treatment Center Rates and Charges Schedule
R9-11-306. Expired
R9-11-307. Expired

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING

Article 4, consisting of Sections R9-11-401 and R9-11-402, made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).

Section
R9-11-401. Definitions
R9-11-402. Reporting Requirements
Table 1. Repealed

ARTICLE 5. EMERGENCY DEPARTMENT DISCHARGE REPORTING

Section
R9-11-501. Definitions
R9-11-502. Reporting Requirements

ARTICLE 1. DEFINITIONS

R9-11-101. Definitions
In this Chapter, unless otherwise specified:
1. “Admission” or “admitted” means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
3. “Allowance” means a charity care discount, self-pay discount, or contractual adjustment.
4. “Arizona facility ID” means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.
5. “Assisted living facility” means the same as in A.R.S. § 36-401.
6. “Attending provider” means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
7. “Available bed” means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.

8. “Bill” means a statement for money owed to a health care institution for the provision of the health care institution’s services.

9. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.

10. “Calendar day” means any day of the week, including a Saturday or a Sunday.

11. “Cardiopulmonary resuscitation” means the same as in A.R.S. § 36-3251.

12. “Charge” means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.

13. “Charge source” means the unit within a health care institution that provided services to an individual for which the individual’s payer source is billed.

14. “Charity care” means services provided without charge to an individual who meets certain financial criteria established by a health care institution.


16. “Chief financial officer” means an individual who is responsible for the financial records of a health care institution.

17. “Classification” means a designation that indicates the types of services a hospital provides.

18. “Clinical evaluation” means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.

19. “Code” means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.

20. “Commodity” means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.

21. “Contractual adjustment” means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.

22. “Control number” means a unique number assigned by a hospital for an individual’s specific episode of care.


24. “Designee” means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.

25. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual’s current medical condition.

26. “Discharge” means a health care institution’s termination of services to a patient or resident for a specific episode of care.

27. “Discharge status” means the disposition of a patient, including whether the patient was:
   a. Discharged home,
   b. Transferred to another health care institution, or
   c. Died.

28. “DNR” means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient’s heart stops beating.

29. “E-code” means an International Classification of Diseases code that is used:
   a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
   b. To further designate the individual’s injury or illness as being caused by events such as:
      i. An external cause of injury, such as a car accident;
      ii. A poisoning; or
      iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.

30. “Electronic” means the same as in A.R.S. § 36-301.


32. “Emergency department” means the unit within a hospital that is designed for the provision of emergency services.

33. “Emergency services” means the same as in A.A.C. R9-10-201.

34. “Episode of care” means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.

35. “Fiscal year” means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.

36. “Governing authority” means the same as in A.R.S. § 36-401.

37. “Health care institution” means the same as in A.R.S. § 36-401.

38. “Health-related services” means the same as in A.R.S. § 36-401.

39. “Home health agency” means the same as in A.R.S. § 36-151.

40. “Home health services” means the same as in A.R.S. § 36-151.

41. “Home office” means the person that is the owner of and controls the functioning of a nursing care institution.

42. “Hospice” means the same as in A.R.S. § 36-401.

43. “Hospital” means the same as in A.A.C. R9-10-201.

44. “Hospital administrator” means the same as “administrator” in A.A.C. R9-10-201.

45. “Hospital services” means the same as in A.A.C. R9-10-201.
46. “Inpatient” means the same as in A.A.C. R9-10-201.
47. “International Classification of Diseases Code” means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
48. “Licensed capacity” means the same as in A.R.S. § 36-401.
49. “Management company” means an entity that:
   a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution,
   b. Takes direction from the governing authority of the nursing care institution, and
   c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
50. “Medical practitioner” means an individual who is:
   a. Licensed:
      i. As a physician;
      ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
      iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
      iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
      v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
      vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or
   b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.
51. “Medical record number” means a unique number assigned by a hospital to an individual for identification purposes.
52. “Medical services” means the same as in A.R.S. § 36-401.
53. “Medicare” means a federal health insurance program established under Title XVIII of the Social Security Act.
54. “National provider identifier” means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.
55. “Newborn” means a human:
   a. Whose birth took place in the reporting hospital, or
   b. Who was:
      i. Born outside a hospital,
      ii. Admitted to the reporting hospital within 24 hours of birth, and
      iii. Admitted to the reporting hospital before being admitted to any other hospital.
56. “Nursing care institution” means the same as in A.R.S. § 36-446.
57. “Nursing care institution administrator” means the same as in A.R.S. § 36-446.
58. “Nursing services” means the same as in A.R.S. § 36-401.
60. “Payer source” means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.
61. “Physician” means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
62. “Principal diagnosis” means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.
63. “Principal procedure” means the procedure judged by an individual working on behalf of a hospital to be:
   a. The most significant procedure performed during an episode of care, or
   b. The procedure most closely associated with a patient’s principal diagnosis.
64. “Priority of visit” means the urgency with which a patient required medical services during an episode of care.
65. “Procedure” means a set of activities performed on a patient that:
   a. Is intended to diagnose or treat a disease, illness, or injury;
   b. Requires the individual performing the set of activities be trained in the set of activities; and
   c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.
66. “Prospective payment system” means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.
67. “Refer” means to direct an individual to a health care institution for services provided by the health care institution.
68. “Referral source” means a code designating the entity that referred or transferred a patient to a hospital.
69. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
70. “Reporting period” means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.
71. “Residence” means the place where an individual lives, such as:
   a. A private home,
   b. A nursing care institution, or
   c. An assisted living facility.
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72. “Resident” means the same as in:
   a. A.A.C. R9-10-701, or
   b. A.A.C. R9-10-901.
73. “Revenue code” means a code for a unit of service that a hospital includes on a bill for hospital services.
74. “Secondary diagnosis” means any diagnosis for an individual other than the principal diagnosis.
75. “Self-pay discount” means a reduction in charges billed to an individual.
76. “Service” means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.
77. “Supportive services” means the same as in A.R.S. § 36-151.
78. “Transfer” means discharging an individual from a health care institution so the individual may be admitted to another health care institution.
79. “Trauma center” means the same as in:
   a. A.R.S. § 36-2201, or
   b. A.R.S. § 36-2225.
81. “Type of” means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:
   a. An employee or contracted worker;
   b. An accounting concept, such as asset, liability, or revenue;
   c. A non-covered ancillary charge;
   d. A payer source;
   e. A charge source;
   f. A medical condition; or
   g. A service.
82. “Type of bed” means a category of available bed that specifies the services provided to an individual occupying the available bed.
83. “Unit” means an area within a health care institution that is designated by the health care institution to provide a specific type of service.
84. “Unit of service” means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.
85. “Written notice” means a document that is provided:
   a. In person,
   b. By delivery service,
   c. By facsimile transmission,
   d. By electronic mail, or
   e. By mail.

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Amended by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-102. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-201 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-103. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-301 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-104. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-302 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).
Title 9, Ch. 11 Arizona Code

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R9-11-105. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-303 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-106. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-304 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-107. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-305 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-108. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-306 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-109. Recodified

Historical Note
Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Section recodified to R9-11-307 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-110. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-111. Repealed

Historical Note
Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-112. Repealed

Historical Note
Added Regulation 2-74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-113. Repealed

Historical Note
Added Regulation 2.74. Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-114. Repealed

Historical Note
Amended effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).
R9-11-115. Repealed

Historical Note
Repealed effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-116. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-117. Repealed

Historical Note
Department correction of Form number (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-118. Repealed

Historical Note
Department correction of language of Regulation heading, Department correction of subsections (B) through (H). Initially this material was available upon request; it is now printed in full (Supp. 75-1). Amended effective June 30, 1987 (Supp. 87-2). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-119. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-120. Repealed

Historical Note
Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-121. Repealed

Historical Note
Department correction of language of regulation heading. Department correction of subsections (B) through (G) initially this materially was available upon request, it is now printed in full (Supp. 75-1). Amended effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 2. ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

R9-11-201. Definitions
In this Article, unless otherwise specified:
1. “Accredited” means the same as in A.R.S. § 36-422.
2. “ALTCS” means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. “Asset” means the same as “asset” in generally accepted accounting principles.
4. “Assisted living facility-based hospice” means a hospice that operates as a part of an assisted living facility.
5. “Audit” means the same as “audit” in generally accepted accounting principles.
6. “Bereavement services” means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual’s death.
7. “Building improvement” means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
8. “Caseload” means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
10. “Chaplain” means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient’s family.
11. “Continuous care” means hospice services provided in a patient’s residence to a patient who requires nursing services to be available 24 hours a day.
12. “Contracted worker” means an individual who:
   a. Performs:
      i. Hospital services in a hospital,
      ii. Nursing services or health-related services in a nursing care institution,
      iii. Hospice services for a hospice, or
      iv. Labor as a medical record coder or transcriptionist for a hospital; and
   b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.

13. “Covered services” means hospice services that are provided to an individual by a hospice and are paid for by a payer source.

14. “Daily census” means a count of the number of patients to whom hospice services were provided during a 24-hour period.

15. “Direct care” means services provided to a resident that require hands-on contact with the resident.


17. “Employee” means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.

18. “Employee-related expenses” means costs incurred by an employer to pay for the employer’s portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.

19. “Equity” means the same as “equity” in generally accepted accounting principles.

20. “Expense” means the same as “expense” in generally accepted accounting principles.

21. “Free-standing” means that a health care institution does not operate as part of another health care institution.

22. “FTE” means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.

23. “Generally accepted accounting principles” means the set of financial reporting standards administered by the Financial Accounting Standards Board, the Governmental Accounting Standards Board, or other specialized bodies dealing with accounting and auditing matters.

24. “Health professional” means the same as in A.R.S. § 32-3201.

25. “Home health agency-based hospice” means a hospice that operates as part of a home health agency.

26. “Hospice administrator” means the chief administrative officer for a hospice.

27. “Hospice chief financial officer” means an individual who is responsible for the financial records of a hospice.

28. “Hospice inpatient facility” means the same as in A.A.C. R9-10-801.

29. “Hospital-based hospice” means a hospice that operates as a part of a hospital.

30. “Inpatient services” means the same as in A.A.C. R9-10-801.

31. “Inpatient surgery” means surgery that requires a patient to receive inpatient services in a hospital.

32. “Level of care” means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.

33. “Liability” means the same as “liability” in generally accepted accounting principles.

34. “Licensed nurse” means a registered nurse practitioner, registered nurse, or practical nurse.

35. “Licensee” means the same as in R9-10-101.

36. “Median length of stay” means the midpoint in the number of patient care days for all patients who were discharged from a hospice during a specific period of time.

37. “Medical record coder” means an individual who assigns codes to a patient’s diagnoses and procedures for billing purposes.

38. “Medical record transcriptionist” means an individual who copies and edits dictation from medical practitioners into medical records.

39. “Medical record coder” means an individual who assigns codes to a patient’s diagnoses and procedures for billing purposes.

40. “Medical record transcriptionist” means an individual who copies and edits dictation from medical practitioners into medical records.

41. “Medicaid” means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.

42. “Nursery patient” means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital’s licensed capacity.

43. “Nursing care institution-based hospice” means a hospice that operates as a part of a nursing care institution.
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51. “Nursing personnel” means the individuals authorized by a health care institution to provide nursing services to a patient or resident.

52. “Occupancy rate” means the midnight census divided by the number of available beds, expressed as a percent.

53. “Operating expense” means the same as “operating expense” in generally accepted accounting principles.

54. “Outpatient hospice services” means hospice services provided at a location outside a hospice inpatient facility.

55. “Outpatient surgery” means surgery that does not require a patient to receive inpatient services in a hospital.


57. “Patient care day” means a calendar day during which a hospice provides hospice services to a patient.

58. “Patient day” means a period during which a patient received inpatient services with:
   a. The time between the midnight census on two successive calendar days counting as one period, and
   b. The day of discharge being counted only when the patient is admitted and discharged on the same day.

59. “Person” means the same as in A.R.S. § 41-1001.

60. “Practical nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.

61. “Registered nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.

62. “Rehabilitation services” means the same as in A.A.C. R9-10-201.

63. “Resident day” means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:
   a. The time between the midnight census on two successive calendar days counting as one period, and
   b. The day of discharge being counted only when the resident is admitted and discharged on the same day.

64. “Revenue” means the same as in A.R.S. § 36-401.

65. “Respite care services” means the services provided in a patient’s residence to a patient who does not require nursing services to be available 24 hours a day.

66. “Rural” means the same as in A.R.S. § 36-2171.

67. “Self-pay” means that charges for hospice services are billed to an individual.

68. “Social worker” means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.

69. “Statement of cash flows” means the same as “statement of cash flows” in generally accepted accounting principles.

70. “Surgery” means the excision of a part of a patient’s body or the incision into a patient’s body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.

71. “Turnover rate” means:
   a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the hospital during a reporting period by the average number of individuals employed during the reporting period; or
   b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a reporting period by the average number of employees during the reporting period.

72. “Vacancy rate” means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital’s reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital’s reporting period.

73. “Volunteer” means the same as in A.A.C. R9-10-801.

Historical Note

Section repealed, new Section adopted effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2). Former R9-11-201 recodified to R9-11-202; new R9-11-201 recodified from R9-11-102 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-202. Hospital Annual Financial Statement

A. A hospital administrator or designee shall submit to the Department, no later than 120 calendar days after the ending date of the hospital’s fiscal year:
   1. An annual financial statement prepared according to generally accepted accounting principles;
   2. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (A)(1); and
If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:

1. Includes the name, physical address, mailing address, and telephone number of the hospital;
2. Includes the name, telephone number, mailing address, and e-mail address of:
   a. The hospital administrator; and
   b. An individual, in addition to the hospital administrator, who may be contacted about the extension request;
3. Includes the date the hospital's annual financial statement and audit of the annual financial statement is due to the Department;
4. Specifies that the hospital is requesting a 30-day extension from submitting the annual financial statement and audit of the annual financial statement required in subsection (A); and
5. Is submitted to the Department at least 30 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department.

The Department shall grant a hospital a 30-day extension for submitting an annual financial statement and audit of the annual financial statement by submitting a written request that:

1. Includes the information specified in subsections (C)(1) through (C)(3);
2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and audit of the annual financial statement, the hospital administrator or designee may submit the combined annual financial statement:
   a. Is prepared according to generally accepted accounting principles,
   b. Contains a financial statement specific to the hospital.

If a hospital is part of a group of health care institutions that prepares a combined annual financial statement and is included in the combined annual financial statement, the hospital administrator or designee may submit the combined annual financial statement if the combined annual financial statement:

1. Is prepared according to generally accepted accounting principles,
2. Identifies the hospital, and
3. Contains a financial statement specific to the hospital.

The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:

1. The reasons for the additional extension request provided according to subsection (F)(4);
2. The length of time for which the additional extension is being requested according to subsection (F)(2); and
3. If the hospital has a history of the following items:
   a. Repeated violations of the same statutes or rules,
   b. Patterns of noncompliance with statutes or rules,
   c. Types of violations of statutes or rules,
   d. Total number of violations of statutes or rules,
   e. Length of time during which violations of statutes or rules have been occurring, and
   f. Noncompliance with an agreement between the Department and the hospital.

The Department shall send written notice of approval of a 30-day extension to a hospital that submits a request for an extension that meets the requirements specified in subsection (C) within seven business days after receiving the request.

If a request by a hospital administrator or designee for a 30-day extension does not meet the requirements specified in subsection (C), the Department shall provide to the hospital a written notice that specifies the missing or incomplete information. If the Department does not receive the missing or incomplete information within 10 calendar days after the date on the written notice, the Department shall consider the hospital's request withdrawn.

Before the end of the 30-day extension specified in subsection (C), a hospital administrator or designee may request an additional extension for submitting an annual financial statement and audit of the annual financial statement by submitting a written request that:

1. Includes the information specified in subsections (C)(1) through (C)(3),
2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and audit of the annual financial statement,
3. Is submitted to the Department at least 14 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department, and
4. Includes the reasons for the additional extension request.

In determining whether to approve or deny a request for a hospital to receive an additional extension as specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement, the Department shall consider the following:

1. The reasons for the additional extension request provided according to subsection (F)(4);
2. The length of time for which the additional extension is being requested according to subsection (F)(2); and
3. If the hospital has a history of the following items:
   a. Repeated violations of the same statutes or rules,
   b. Patterns of noncompliance with statutes or rules,
   c. Types of violations of statutes or rules,
   d. Total number of violations of statutes or rules,
   e. Length of time during which violations of statutes or rules have been occurring, and
   f. Noncompliance with an agreement between the Department and the hospital.

The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement within seven business days after receiving the request.

If the Department denies a request for an additional extension specified in subsection (F), a hospital may appeal the denial according to A.R.S. Title 41, Article 6, Article 10.

If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.
R9-11-203. Hospital Uniform Accounting Report
A. A hospital administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the hospital’s fiscal year.
B. A hospital administrator or designee shall submit a copy of the hospital’s Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).
C. The uniform accounting report required in subsection (A) shall include the following information:
1. The name, physical address, mailing address, county, and telephone number of the hospital;
   a. Hospital administrator,
   b. Hospital chief financial officer, and
   c. Individual who prepared the uniform accounting report;
2. The identification number assigned to the hospital:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the hospital’s national provider identifier;
3. The hospital’s classification;
4. The hospital’s classification;
5. Whether the entity that is the owner of the hospital is:
   a. Not for profit;
   b. For profit; or
   c. A federal, state, or local government agency;
6. Whether or not the hospital is Medicare-certified;
7. The ending date of the hospital’s reporting period;
8. If the hospital began operations during the hospital’s reporting period, the date on which the hospital began operations;
9. The date the uniform accounting report was submitted to the Department;
10. The licensed capacity, for each type of bed, at the end of the reporting period;
11. The number of available beds, for each type of bed, at the end of the reporting period;
12. The number of available beds at the end of the reporting period;
13. The number of admissions, for each type of bed, during the reporting period;
14. The total number of admissions during the reporting period;
15. The total number of admissions during the reporting period;
16. The total number of patient days:
   a. During the reporting period, and
   b. For each type of bed during the reporting period;
17. The average occupancy rate for the reporting period;
18. The number of inpatient surgeries during the reporting period;
19. The number of outpatient surgeries during the reporting period;
20. The number of births during the reporting period;
21. The number of nursery patient admissions during the reporting period;
22. The number of patient days for nursery patients during the reporting period;
23. The number of episodes of care during the reporting period provided by the:
   a. Emergency department,
   b. Urgent care unit, and
   c. Trauma center;
24. The total number of episodes of care during the reporting period provided by the emergency department, urgent care unit, or trauma center;
25. The number of episodes of care in the emergency department, urgent care unit, or trauma center during the reporting period for which the patient was subsequently admitted to the hospital;
26. The total number of FTEs at the end of the reporting period;
27. The turnover rate for the reporting period;
28. The vacancy rate for the reporting period;
29. The number of FTEs, for each type of employee, during the reporting period;
30. The vacancy rate, for each type of employee, for the reporting period;
31. The number of medical record coder FTEs during the reporting period;
32. The vacancy rate for medical record coders for the reporting period;
33. The number of medical record transcriptionist FTEs during the reporting period;
34. The vacancy rate for medical record transcriptionists for the reporting period;
35. For individuals who worked for the hospital as contracted workers during the reporting period, the number of hours worked by registered nurses;
36. The amount of revenue generated, for each type of revenue, by the hospital during the reporting period;
37. The amount of allowances given, for each type of allowance, by the hospital during the reporting period;
38. The total amount of revenue generated and allowances given by the hospital during the reporting period;
39. The operating expenses incurred, for each type of operating expense, by the hospital during the reporting period;
40. The total operating expenses incurred by the hospital during the reporting period;
41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospital during the reporting period;
43. The amount of assets, for each type of asset, of the hospital at the end of the reporting period;
44. The total amount of assets of the hospital at the end of the reporting period;
45. The amount of liabilities, for each type of liability, of the hospital at the end of the reporting period;
46. The total amount of liabilities of the hospital at the end of the reporting period;
47. The amount of net assets, for each type of net asset, of the hospital at the end of the reporting period;
48. The total amount of net assets of the hospital at the end of the reporting period;
49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and
50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3), unless the statement of cash flows has been submitted as part of the annual financial statement required in R9-11-202.

D. A hospital administrator or designee shall:
1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not complete;
      iii. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
      iv. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and
2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospital administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:
1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

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ii. Management company, if applicable;

6. The beginning and ending dates of the nursing care institution’s reporting period;

7. If the nursing care institution began operations during the nursing care institution’s reporting period, the date on which the nursing care institution began operations;

8. The date the uniform accounting report was submitted to the Department;

9. Whether the entity that is the owner of the nursing care institution is:
   a. Not for profit;
   b. For profit; or
   c. A federal, state, or local government agency;

10. Whether or not the nursing care institution is Medicare-certified;

11. The licensed capacity at the beginning and end of the reporting period;

12. The total number of available beds at the beginning and end of the reporting period;

13. If the nursing care institution has a distinct unit for patients whose payer source is Medicare, the number of licensed beds in that unit at the beginning and end of the reporting period;

14. The number of resident admissions during the reporting period;

15. The number of resident days during the reporting period:
   a. For each payer source that is not ALTCS, and
   b. For each level of care for residents whose payer source is ALTCS;

16. The total number of resident days during the reporting period;

17. The average occupancy rate for the reporting period;

18. The number of paid hours during the reporting period for each of the following types of employees:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

19. The number of hours worked during the reporting period by each of the following types of employees:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

20. The amount in salaries paid, excluding employee-related expenses, for each of the following types of employees:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

21. The number of each of the following types of employees at the beginning of the reporting period:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

22. The number of each of the following types of employees at the end of the reporting period:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

23. For staff employed by the nursing care institution during the reporting period as registered nurses, practical nurses, or certified nursing assistants, the total:
   a. Number of paid hours;
   b. Number of hours worked;
   c. Amount in salaries paid, excluding employee-related expenses;
   d. Number of staff at the beginning of the reporting period; and
   e. Number of staff at the end of the reporting period;

24. The turnover rate for the reporting period for:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

25. The total turnover rate for the reporting period for all employees of the nursing care institution who are registered nurses, practical nurses, or certified nursing assistants;

26. The number of hours worked during the reporting period by each of the following types of contracted workers:
   a. Registered nurses,
   b. Practical nurses, and
   c. Certified nursing assistants;

27. The total number of hours worked during the reporting period by contracted workers who are registered nurses, practical nurses, or certified nursing assistants;

28. The amount paid during the reporting period for each of the following types of contracted workers:
   a. Registered nurses,
   b. Practical nurses, and
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c. Certified nursing assistants;

29. The total amount paid during the reporting period to contracted workers who are registered nurses, practical nurses, or certified nursing assistants;

30. The amount of revenue generated and allowances given, for each type of revenue or allowance, by the nursing care institution during the reporting period;

31. The total amount of revenue generated and allowances given by the nursing care institution during the reporting period;

32. The operating expenses incurred by the nursing care institution during the reporting period for each type of operating expense;

33. The total operating expenses incurred by the nursing care institution during the reporting period;

34. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the nursing care institution during the reporting period;

35. The charges for non-covered ancillary services during the reporting period:
   a. For each type of non-covered ancillary service,
   b. For each type of payer source, and
   c. For each type of non-covered ancillary service for each type of payer source;

36. The total amount of non-covered ancillary charges for the reporting period;

37. If the nursing care institution has documentation of building improvement costs that:
   a. Affected the licensed capacity:
      i. The year in which each building improvement was completed;
      ii. The cost of each building improvement;
      iii. The licensed capacity before the building improvement was begun;
      iv. The number of beds that were added as a result of the building improvement, if applicable;
      v. The number of beds that were removed as a result of the building improvement, if applicable; and
      vi. The licensed capacity after the building improvement was completed; and
   b. Did not affect the licensed capacity:
      i. The year in which each building improvement was completed; and
      ii. The cost of each building improvement;

38. The amount of assets, for each type of asset, of the nursing care institution at the end of the reporting period;

39. The total amount of assets of the nursing care institution at the end of the reporting period;

40. The amount of liabilities, for each type of liability, of the nursing care institution at the end of the reporting period;

41. The total amount of liabilities of the nursing care institution at the end of the reporting period;

42. The amount of equity, for each type of equity, of the nursing care institution at the end of the reporting period;

43. The total amount of equity of the nursing care institution at the end of the reporting period;

44. The difference between the amount identified in subsection (C)(43) and the amount identified in subsection (C)(41); and

45. An equity reconciliation statement, including:
   a. Net equity at the beginning of the reporting period;
   b. The difference between the amount identified in subsection (C)(31) and the amount identified in subsection (C)(33);
   c. Additions to equity, for each type of additional equity, for the reporting period;
   d. The total amount of additional equity for the reporting period;
   e. Deductions from equity, for each type of equity deduction, for the reporting period;
   f. The total amount of equity deduction for the reporting period; and
   g. Net equity at the end of the reporting period.

D. A nursing care institution administrator or designee shall:

1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not complete;
      iii. State what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
      iv. Attest that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A nursing care institution administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department’s letter requesting a second revision.
F. If a nursing care institution administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

**Historical Note**
New Section made by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

**R9-11-205. Hospice Uniform Accounting Report**

A. A hospice administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, within 150 calendar days after the end of the hospice’s fiscal year.

B. A hospice administrator or designee shall submit a copy of the hospice’s Medicare and Medicaid cost reports, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospice;
2. The identification number assigned to the hospice:
   a. By the Department;
   b. By AHCCCS, if applicable;
   c. By Medicare, if applicable; and
   d. As the hospice’s national provider identifier;
3. The beginning and ending dates of the hospice’s reporting period;
4. If the hospice began operations during the hospice’s reporting period, the date on which the hospice began operations;
5. The name, telephone number, and e-mail address of the:
   a. Hospice administrator,
   b. Hospice chief financial officer, and
   c. Individual who prepared the uniform accounting report;
6. The date the uniform accounting report was submitted to the Department;
7. Whether the hospice operates as a:
   a. Hospice service agency, or
   b. Hospice service agency with one or more hospice inpatient facilities;
8. Whether the entity that is the owner of the hospice is:
   a. Not for profit;
   b. For profit; or
   c. A federal, state, or local government agency;
9. Whether or not the hospice is Medicare-certified;
10. The entity by which the hospice is accredited, if applicable;
11. Whether the hospice provides hospice services in an area that:
   a. Is equal to or more than two-thirds urban,
   b. Is equal to or more than two-thirds rural, or
   c. Is less than two-thirds urban and less than two-thirds rural;
12. Whether the hospice is:
   a. Free-standing,
   b. A hospital-based hospice,
   c. A nursing care institution-based hospice,
   d. An assisted living facility-based hospice, or
   e. A home health agency-based hospice;
13. If the hospice operates one or more hospice inpatient facilities, list for each hospice inpatient facility:
   a. The identification number assigned to the hospice inpatient facility by the Department;
   b. Whether the hospice inpatient facility is:
      i. Located within a hospital;
      ii. Located within a nursing care institution;
      iii. Located within an assisted living facility; or
      iv. Not located within a hospital, nursing care institution, or assisted living facility;
   c. The levels of care provided;
   d. The licensed capacity of the hospice inpatient facility;
   e. The total number of available beds at the beginning and end of the reporting period; and
   f. The average occupancy rate for the reporting period;
14. The number of patients during the reporting period that were:
   a. Referred to the hospice,
   b. Admitted to the hospice,
   c. Died while admitted to the hospice, and
   d. Discharged from the hospice while living;
15. The number of patient care days, for all patients, during the reporting period in which the hospice provided:
   a. Routine home care,
b. Respite care services,
c. Continuous care, and
d. Inpatient services;
16. The total number of patient care days during the reporting period for all patients;
17. The average daily census for the reporting period, calculated as the number specified in subsection (C)(16) divided by the number of days in the reporting period;
18. Average length of stay, calculated as the number of patient care days for patients discharged during the reporting period divided by the sum of the numbers specified in subsections (C)(14)(c) and (C)(14)(d);
19. Median length of stay for patients discharged during the reporting period;
20. The number of patients admitted to the hospice during the reporting period:
   a. By gender;
   b. By age group;
   c. By race and ethnicity;
   d. From:
      i. A private home owned or leased by, or on behalf of, a patient;
      ii. An assisted living facility;
      iii. A nursing care institution;
      iv. A hospital; and
      v. A hospice;
   e. With a principal diagnosis of:
      i. Cancer,
      ii. Heart disease,
      iii. Dementia,
      iv. Lung disease,
      v. Kidney disease,
      vi. Stroke or coma,
      vii. Liver disease,
      viii. HIV-related disease,
      ix. Motor neuron disorder,
      x. Unspecified debility, and
      xi. A disease not specified in subsections (C)(20)(e)(i) through (C)(20)(e)(x); and
   f. Whose payer source is:
      i. Medicare,
      ii. AHCCCS,
      iii. Self-pay,
      iv. A private insurance company, and
      v. A payer source not specified in subsections (C)(20)(f)(i) through (C)(20)(f)(iv);
21. The total number of patient care days during the reporting period that the hospice provided hospice services to a patient whose principal diagnosis was related to:
   a. Cancer,
   b. Heart disease,
   c. Dementia,
   d. Lung disease,
   e. Kidney disease,
   f. Stroke or Coma,
   g. Liver disease,
   h. HIV-related disease,
   i. Motor neuron disorder,
   j. Unspecified debility, and
   k. Any other disease not specified in subsections (C)(21)(a) through (C)(21)(j);
22. The number of FTEs providing hospice services, for each type of employee, during the reporting period;
23. The total number of FTEs providing hospice services during the reporting period;
24. The average caseload during the reporting period for a licensed nurse, calculated as the total number of patients assigned to licensed nurses working for the hospice during the reporting period, divided by the total number of licensed nurses working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
   b. Hospice services provided in hospice inpatient facilities;
25. The average caseload during the reporting period for a social worker, calculated as the total number of patients assigned to social workers working for the hospice during the reporting period, divided by the total number of social workers working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
26. The average caseload during the reporting period for nursing personnel other than a licensed nurse, calculated as the total number of patients assigned to nursing personnel other than licensed nurses working for the hospice during the reporting period, divided by the total number of nursing personnel other than licensed nurses working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
   b. Hospice services provided in hospice inpatient facilities;

27. The average caseload during the reporting period for a chaplain, calculated as the total number of patients assigned to chaplains working for the hospice during the reporting period, divided by the total number of chaplains working for the hospice during the reporting period, for:
   a. Outpatient hospice services, and
   b. Hospice services provided in hospice inpatient facilities;

28. The number of individuals who received bereavement services from the hospice during the reporting period;

29. The number of individuals from the hospice who provided bereavement services during the reporting period;

30. The total number of volunteers during the reporting period;

31. The total number of hours that volunteers provided hospice services during the reporting period;

32. The number of patient care days during the reporting period, for whom:
   a. The payer source was:
      i. Medicare,
      ii. AHCCCS,
      iii. Self-pay,
      iv. A private insurance company, and
      v. A payer source not specified in subsections (C)(32)(a)(i) through (C)(32)(a)(iv), and
   b. There was no payer source identified;

33. The total number of patient care days specified in subsections (C)(32);

34. The total amount of money billed, during the reporting period to:
   a. Medicare,
   b. AHCCCS,
   c. Self-pay,
   d. A private insurance company, and
   e. A payer source not specified in subsections (C)(34)(a) through (C)(34)(d);

35. The total amount of money billed during the reporting period;

36. The amount of revenue generated, for each type of revenue, by the hospice during the reporting period;

37. The amount of allowances given, for each type of allowance, by the hospice during the reporting period;

38. The total amount of revenue generated and allowances given by the hospice during the reporting period;

39. The operating expenses incurred, for each type of operating expense, by the hospice during the reporting period;

40. The total operating expenses incurred by the hospice during the reporting period;

41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);

42. The income and expenses, other than revenue and operating expenses, for each type of income received and expense incurred by the hospice during the reporting period;

43. The amount of assets, for each type of asset, of the hospice at the end of the reporting period;

44. The total amount of assets of the hospice at the end of the reporting period;

45. The amount of liabilities, for each type of liability, of the hospice at the end of the reporting period;

46. The total amount of liabilities of the hospice at the end of the reporting period;

47. The amount of net assets, for each type of net asset, of the hospice at the end of the reporting period;

48. The total amount of net assets of the hospice at the end of the reporting period;

49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and

50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3).

D. A hospice administrator or designee shall:

1. On a form provided by the Department:
   a. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; or
   b. If the hospice administrator or designee has personal knowledge that the information submitted according to subsections (B) and (C) is not accurate or not complete:
      i. Identify the information that is not accurate or not complete;
      ii. Describe the circumstances that make the information not accurate or not complete;
      iii. State what actions the hospice is taking to correct the inaccurate information or make the information complete; and
      iv. Attest that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C), except the information identified in subsection (D)(1)(b)(i), is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).
E. A hospice administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:
1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.
F. If a hospice administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

Historical Note
New Section made by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-206. Reserved
R9-11-207. Reserved
R9-11-208. Reserved
R9-11-209. Reserved
R9-11-210. Reserved
R9-11-211. Repealed

Historical Note
Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-212. Repealed

Historical Note
Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

R9-11-213. Repealed

Historical Note
Adopted effective January 16, 1976 (Supp. 76-1). Repealed effective June 25, 1993, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1992, Ch. 197, § 2; received in the Office of the Secretary of State June 10, 1993 (Supp. 93-2).

ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. Definitions
In this Article, unless otherwise specified:
1. “Adolescent” means an individual the hospital designates as an adolescent based on the hospital’s criteria.
2. “Adult” means the same as in A.A.C. R9-10-201.
4. “Blood bank cross match” means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
5. “Complete blood count with differential” means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual’s blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
6. “Contrast medium” means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
7. “CT” means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.
8. “Current rates and charges information” means the most recent rates and charges schedule for a health care institution on file with the Department, and all documents changing the most recent rates and charges schedule.
10. “EEG” means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.
11. “EKG” means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. “Facility” means a building and associated personnel and equipment that perform a particular service or activity.
13. “Formulary” means a list of drugs that are available to a patient through a hospital.
15. “Home health agency administrator” means the chief administrative officer for a home health agency.
16. “Hospital department” means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. “Implementation date” means the month, day, and year a health care institution intends to begin using specific rates and charges when billing a patient or resident.
18. “Intensive care bed” means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. “IVP” means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. “Labor and delivery” means services provided to a woman related to childbirth.
21. “Lithotripsy” means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. “Mark-up” means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. “MRI” means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. “Neonate” means the same as in A.A.C. R9-10-201.
25. “Nursery bed” means an available bed used to provide hospital services to a neonate.
27. “Outpatient treatment center administrator” means the chief administrative officer for an outpatient treatment center.
28. “Overview form” means a document:
   a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital’s current rates and charges information, and
   b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. “Pediatric” means the same as in A.A.C. R9-10-201.
30. “Pediatric bed” means an available bed used to provide hospital services to a pediatric patient.
32. “Post-hospital extended care services” means the services that are described in and meet the requirements of 42 CFR 409.31.
33. “Private room” means a room that contains one available bed.
34. “Rate” means a specific dollar amount per unit of service set by a health care institution.
35. “Rates and charges schedule” means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.
36. “Rehabilitation bed” means a type of bed used to provide services to a patient to restore or to optimize the patient’s functional capability.
37. “Review” means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.
38. “Semi-private room” means a room that contains two available beds.
39. “Skilled nursing bed” means an available bed used for a patient requiring skilled nursing services.
40. “Skilled nursing services” means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.
41. “Small volume nebulizer” means a device that:
   a. Holds liquid medicine that is turned into a mist by an air compressor, and
   b. Is used for treatments lasting less than 20 minutes.
42. “Swing bed” means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.
43. “Swing-bed hospital” means the same as in 42 CFR 413.114.
44. “Trauma team activation” means a notification by a health care institution:
   a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;
   b. That is based on a patient’s triage information; and
   c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.
45. “Ultrasound” means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.

Historical Note
iv. As the hospital’s national provider identifier;

c. The name, telephone number, and e-mail address of:
   i. The hospital administrator,
   ii. The hospital chief financial officer, and
   iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and

d. The planned implementation date for the rates and charges;

2. A rates and charges schedule prepared as specified in subsection (B); and

3. A form provided by the Department, on which the hospital administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B) is accurate and complete; or
   b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (B) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.

B. A hospital administrator shall ensure that a rates and charges schedule:
   1. Contains a table of contents for the rates and charges schedule that lists:
      a. The beginning line number or page number for the hospital rates and charges overview form required in subsection (B)(2);
      b. For each hospital department:
         i. The hospital department’s name and identification number,
         ii. The beginning line number or page number of the rates and charges schedule for the hospital department, and
         iii. The charge source’s name and identification number for each charge source within the hospital department;
      c. The beginning line number or page number for the list required in subsection (B)(4) that matches the name of each charge source with its charge source identification number;
      d. The beginning line number or page number for the formula section for formulary, commodity, and contracted services mark-ups required in subsection (B)(5); and
      e. The beginning line number or page number for the copy of the hospital’s allowance rules and formulae required in subsection (B)(6);
   2. Contains an overview form, in a format specified by the Department, that includes:
      a. The hospital’s name, city, and county;
      b. The identification number assigned to the hospital by the Department;
      c. The name, telephone number, and e-mail of the individual who prepared the overview form;
      d. The date the overview form was submitted to the Department;
      e. The hospital’s licensed capacity;
      f. Whether the entity that is the owner of the hospital is:
         i. Not for profit;
         ii. For profit; or
         iii. A federal, state, or local government agency;
      g. The hospital’s classification;
      h. The planned implementation date for the rates and charges in the overview form;
      i. The total percent increase of the rates and charges listed in the overview form compared with the rates and charges from the last overview form, if applicable;
      j. The date the overview form was last changed, if applicable;
      k. The daily charge for a private room;
      l. The daily charge for a semi-private room;
      m. The daily charge for a pediatric bed;
      n. The daily charge for a nursery bed;
      o. The daily charge for a pediatric intensive care bed;
      p. The daily charge for a neonatal intensive care bed;
      q. The daily charge for a cardiovascular intensive care bed;
      r. The daily charge for a swing bed;
      s. The daily charge for a rehabilitation bed;
      t. The daily charge for a skilled nursing bed;
      u. The minimum charges for labor and delivery;
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v. The minimum charge for trauma team activation;
w. The minimum charge for an EEG;
x. The minimum charge for an EKG;
y. The minimum charge for a complete blood count with differential;
z. The minimum charge for a blood bank crossmatch;
aa. The minimum charge for a lithotripsy;
bb. The minimum charge for an x-ray;
cc. The minimum charge for an IVP;
dd. The minimum charge for a respiratory therapy session with a small volume nebulizer;
e. The minimum charge for a CT scan of a head without contrast medium;
ff. The minimum charge for a CT scan of an abdomen with contrast medium;
gg. The minimum charge for an abdomen ultrasound;
hh. The minimum charge for a brain MRI without contrast medium;
i. The minimum charge for 15 minutes of physical therapy;
jj. The daily rate for behavioral health services for:
   i. An adult patient,
   ii. An adolescent patient, and
   iii. A pediatric patient; and
kk. The code, if applicable, for the units of service specified in subsections (B)(2)(k) through (B)(2)(jj);

3. Lists for each hospital department, in a format specified by the Department:
a. The hospital department name and identification number;
b. The charge source name and identification number for each charge source within the hospital department; and
c. For each unit of service offered by the hospital for which a separate rate or charge is billed from the charge source:
   i. The unit of service code;
   ii. A description of the unit of service;
   iii. The rate or charge for the unit of service; and
   iv. The number of times a separate charge was billed for the unit of service during the previous 12 months, if applicable;

4. Contains a list that matches the name of each charge source with its charge source identification number;

5. Contains a formula section for formulary, commodity, and contracted services mark-ups; and

6. Contains a copy of the hospital’s allowance rules and formulae, if applicable.

C. To change a hospital’s current rates and charges information, a hospital administrator or designee shall submit to the Department:

1. A cover letter:
a. Containing the information specified in subsection (A)(1), and
b. Stating that the accompanying information is changing the hospital’s current rates and charges information;

2. Either:
a. The rates and charges schedule specified in subsection (A)(2); or
b. The following information:
   i. A description of:
      (1) The current and new rate or charge for each unit of service undergoing a change;
      (2) The name of each charge source undergoing a change and its charge source identification number;
      (3) The current and new formulary, commodity, and contracted services formulae for each change in the hospital’s mark-up;
      (4) The current and new allowance rules and formulae for each change in the hospital’s allowance rules and formulae; and
      (5) How the hospital rates and charges overview form required in subsection (B)(2) is affected by the changes specified in subsections (C)(2)(b)(i)(1) through (C)(2)(b)(i)(4);
   ii. The line number or page number in the hospital’s current rates and charges information for each change listed in subsection (C)(2)(b)(i); and
   iii. A list of each previous change:
      (1) To a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or
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formula being changed;

(2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (C)(2)(a); and

(3) Including:

(a) The date the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

(b) A description of how the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

3. A form provided by the Department, on which the hospital administrator or designee:

a. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (C)(1) and (C)(2) is accurate and complete; or

b. If the hospital administrator or designee has personal knowledge that the information submitted according to subsections (C)(1) and (C)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the hospital is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (C)(1) and (C)(2), except the information identified in subsection (C)(3)(b)(i), is accurate and complete.

D. A hospital administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the hospital but not earlier than:

1. The date the Department notifies the hospital that the Department has completed a review of the rates and charges schedule, or

2. Sixty calendar days after the Department notifies the hospital that the Department received the rates and charges schedule.

E. A hospital administrator shall implement a change in the hospital’s current rates and charges information submitted as specified in subsection (C):

1. That is:

   a. A new rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
   b. An increase in a rate or charge;
   c. A change to a formulary, commodity, or contracted services formula, which results in an increase in a rate or charge; or
   d. A change to an allowance rule or formula, which results in an increase in a rate or charge; and

2. On a date determined by the hospital, but not earlier than:

   a. The date the Department notifies the hospital that the Department has completed a review of the information submitted as specified in subsection (C), or
   b. Sixty calendar days after the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

F. A hospital administrator shall implement a change in the hospital’s current rates and charges information submitted as specified in subsection (C):

1. That is:

   a. A deletion of a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
   b. A reduction in a rate or charge;
   c. A change to a formulary, commodity, or contracted services formula, which results in a reduction in a rate or charge; or
   d. A change to an allowance rule or formula, which results in a reduction in a rate or charge; and

2. On a date:

   a. Determined by the hospital, and
   b. Not earlier than the date the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

G. When the Department receives from a hospital a rates and charges schedule submitted as specified in subsection (A), or a change in the hospital’s current rates and charges information submitted as specified in subsection (C), the Department shall:

1. Provide written notice to the hospital within five business days of receipt of the rates and charges information, and

2. Provide written notice to the hospital within 60 calendar days that the Department has reviewed the rates and charges information.

H. A hospital administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the hospital’s current rates and charges information not prepared as speci-
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fied in subsection (C), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

I. If a hospital administrator or designee does not submit a rates and charges schedule or information about changes to the hospital’s rates or charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

Historical Note


Table 1. Recodified

Historical Note

Adopted effective February 22, 1995, through an exemption from A.R.S. Title 41, Chapter 6 pursuant to Laws 1994, Ch. 115, § 9 (Supp. 95-1). Table 1 recodified to Article 4 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3).

R9-11-303. Nursing Care Institution Rates and Charges Schedule

A. Before a nursing care institution provides services to residents, a nursing care institution administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:
   a. The name, physical address, mailing address, county, and telephone number of the nursing care institution;
   b. The name, physical address, mailing address, and telephone number of the nursing care institution’s:
      i. Home office, if applicable; and
      ii. Management company, if applicable;
   c. The identification number assigned to the nursing care institution:
      i. By the Department;
      ii. By AHCCCS, if applicable;
      iii. By Medicare, if applicable; and
      iv. As the nursing care institution’s national provider identifier;
   d. The name, telephone number, and e-mail address of:
      i. The nursing care institution administrator,
      ii. The nursing care institution chief financial officer, and
      iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
   e. The planned implementation date for the rates and charges;

2. A rates and charges schedule, in a format specified by the Department, containing:
   a. A table of contents;
   b. A description of and the rates and charges for:
      i. Each type of bed; and
      ii. Each unit of service, other than a type of bed, for which a separate rate or charge is billed; and
   c. A copy of any nursing care institution rules or formulae which may affect the rate or charge for a type of bed or other unit of service; and

3. A form provided by the Department, on which the nursing care institution administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
   b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
   iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.

B. To change a nursing care institution’s current rates and charges information, a nursing care institution administrator or designee shall submit to the Department:

1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the nursing care institution’s current rates and charges information;
2. Either:
   a. The rates and charges schedule specified in subsection (A)(2); or
   b. The following information:
      i. A description of:
         (1) The current and new rate or charge for each type of bed or other unit of service undergoing a change, and
         (2) The current and new rules and formulae for each change to the nursing care institution rules or formulae that may affect the rate or charge for a type of bed or other unit of service;
      ii. The line number or page number in the nursing care institution’s current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
      iii. A list of each previous change:
         (1) To a rate, charge, rule, or formula being changed;
         (2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (B)(2)(a); and
         (3) Including:
            (a) The date the rate, charge, rule, or formula was previously changed; and
            (b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the nursing care institution administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or
   b. If the nursing care institution administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the nursing care institution is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the nursing care institution administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. A nursing care institution administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the nursing care institution but not earlier than:
   1. The date the Department notifies the nursing care institution that the Department has completed a review of the rates and charges schedule, or
   2. Sixty calendar days after the Department notifies the nursing care institution that the Department received the rates and charges schedule.

D. A nursing care institution administrator shall implement a change in the nursing care institution’s current rates and charges information submitted as specified in subsection (B):
   1. That is:
      a. A new rate, charge, rule, or formula;
      b. An increase in a rate or charge; or
      c. A change to a rule or formula, which results in an increase in a rate or charge; and
   2. On a date determined by the nursing care institution, but not earlier than:
      a. The date the Department notifies the nursing care institution that the Department has completed a review of the information submitted as specified in subsection (B), or
      b. Sixty calendar days after the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).

E. A nursing care institution administrator shall implement a change in the nursing care institution’s current rates and charges information submitted as specified in subsection (B):
   1. That is:
      a. A deletion of rate or charge;
      b. A reduction in a rate or charge; or
      c. A change to a rule or formula, which results in a reduction in a rate or charge; and
2. On a date:
   a. Determined by the nursing care institution, and
   b. Not earlier than the date the Department notifies the nursing care institution that the Department received the information submitted as specified in subsection (B).

F. When the Department receives from a nursing care institution a rates and charges schedule submitted as specified in subsection (A), or a change in the nursing care institution’s current rates and charges information submitted as specified in subsection (B), the Department shall:
   1. Provide written notice to the nursing care institution within five business days of receipt of the rates and charges information, and
   2. Provide written notice to the nursing care institution within 60 calendar days that the Department has reviewed the rates and charges information.

G. A nursing care institution administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the nursing care institution’s current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:
   1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
   2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

H. If a nursing care institution administrator or designee does not submit a rates and charges schedule or information about changes to the nursing care institution’s rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

Historical Note
Section recodified from R9-11-105 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-304. Home Health Agency Rates and Charges Schedule
A. Before a home health agency provides services to patients, a home health agency administrator or designee shall submit to the Department a rates and charges package that contains:
   1. A cover letter that includes:
      a. The name, physical address, mailing address, county, and telephone number of the home health agency;
      b. The identification number assigned to the home health agency:
         i. By the Department;
         ii. By AHCCCS, if applicable;
         iii. By Medicare, if applicable; and
         iv. As the home health agency’s national provider identifier;
      c. The name, telephone number, and e-mail address of:
         i. The home health agency administrator,
         ii. The home health agency chief financial officer, and
         iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
      d. The planned implementation date for the rates and charges;
   2. Either:
      a. A rates and charges schedule, in a format specified by the Department, containing:
         i. A table of contents;
         ii. For each unit of service offered for which a separate rate or charge is billed:
            (1) The unit of service code,
            (2) A description of the unit of service, and
            (3) The rate or charge for the unit of service;
         iii. A copy of any home health agency rules or formulae that may affect the rate or charge for a unit of service; or
      b. Current cost reports and financial information that the home health agency files for other government reporting purposes if the current cost reports and financial information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and
   3. A form provided by the Department, on which the home health agency administrator or designee:
      a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
      b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
         i. Identifies the information that is not accurate or not complete;
         ii. Describes the circumstances that make the information not accurate or not complete;
         iii. States what actions the home health agency is taking to correct the inaccurate information or make the
B. To change a home health agency’s current rates and charges information, a home health agency administrator or designee shall submit to the Department:

1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the home health agency’s current rates and charges information;

2. Either:
   a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
   b. The following information:
      i. A description of:
         (1) The current and new rate or charge for each unit of service undergoing a change, and
         (2) The current and new rules and formulae for each change to the home health agency rules or formulae which may affect the rate or charge for a unit of service;
      ii. The line number or page number in the home health agency’s current rates and charges information for each change listed in subsection (B)(2)(b)(i); and
      iii. A list of each previous change:
         (1) To a rate, charge, rule, or formula being changed;
         (2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and
         (3) Including:
            (a) The date the rate, charge, rule, or formula was previously changed; and
            (b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the home health agency administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or
   b. If the home health agency administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the home health agency is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the home health agency administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. A home health agency administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the home health agency’s current rates and charges information submitted as specified in subsection (B) on a date determined by the home health agency but not earlier than the date the Department notifies the home health agency that the Department received the rates and charges information.

D. When the Department receives from a home health agency a rates and charges schedule submitted as specified in subsection (A) or a change in the home health agency’s current rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the home health agency within five business days of receipt of the rates and charges information.

E. A home health agency administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the home health agency’s current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.
F. If a home health agency administrator or designee does not submit a rates and charges schedule or information about changes to the home health agency’s rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

Historical Note

R9-11-305. Outpatient Treatment Center Rates and Charges Schedule
A. Before an outpatient treatment center provides services to patients, an outpatient treatment center administrator or designee shall submit to the Department a rates and charges package that contains:
1. A cover letter that includes:
   a. The name, physical address, mailing address, county, and telephone number of the outpatient treatment center;
   b. The identification number assigned to the outpatient treatment center:
      i. By the Department;
      ii. By AHCCCS, if applicable;
      iii. By Medicare, if applicable; and
      iv. As the outpatient treatment center’s national provider identifier;
   c. The name, telephone number, and e-mail address of:
      i. The outpatient treatment center administrator,
      ii. The outpatient treatment center chief financial officer, and
      iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and
   d. The planned implementation date for the rates and charges;
2. Either:
   a. A rates and charges schedule, in a format specified by the Department, containing:
      i. A table of contents;
      ii. For each unit of service offered for which a separate rate or charge is billed:
         (1) The unit of service code,
         (2) A description of the unit of service, and
         (3) The rate or charge for the unit of service;
      iii. A copy of any outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service; or
   b. Current cost reports and financial information that the outpatient treatment center files for other government reporting purposes if the current cost reports and financial information submitted to the Department contain the information required in subsections (A)(2)(a)(ii) and (A)(2)(a)(iii); and
3. A form provided by the Department, on which the outpatient treatment center administrator or designee:
   a. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (A)(1) and (A)(2) is accurate and complete; or
   b. If the outpatient treatment center administrator or designee has personal knowledge that the information submitted according to subsections (A)(1) and (A)(2) is not accurate or not complete:
      i. Identifies the information that is not accurate or not complete;
      ii. Describes the circumstances that make the information not accurate or not complete;
      iii. States what actions the outpatient treatment center is taking to correct the inaccurate information or make the information complete; and
      iv. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (A)(1) and (A)(2), except the information identified in subsection (A)(3)(b)(i), is accurate and complete.
B. To change an outpatient treatment center’s current rates and charges information, an outpatient treatment center administrator or designee shall submit to the Department:
1. A cover letter:
   a. Containing the information specified in subsection (A)(1), and
   b. Stating that the accompanying information is changing the outpatient treatment center’s current rates and charges information;
2. Either:
   a. The rates and charges schedule specified in subsection (A)(2)(a) or the current cost reports and financial information specified in subsection (A)(2)(b); or
   b. The following information:
      i. A description of:
(1) The current and new rate or charge for each unit of service undergoing a change,

(2) The current and new rules and formulae for each change to the outpatient treatment center rules or formulae which may affect the rate or charge for a unit of service;

ii. The line number or page number in the outpatient treatment center’s current rates and charges information for each change listed in subsection (B)(2)(b)(i); and

iii. A list of each previous change:

(1) To a rate, charge, rule, or formula being changed;

(2) That was submitted since the last submission made according to subsection (A)(2) or (B)(2)(a); and

(3) Including:

(a) The date the rate, charge, rule, or formula was previously changed; and

(b) A description of how the rate, charge, rule, or formula was previously changed; and

3. A form provided by the Department, on which the outpatient treatment center administrator or designee:

a. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2) is accurate and complete; or

b. If the outpatient treatment center administrator or designee has personal knowledge that the information submitted according to subsections (B)(1) and (B)(2) is not accurate or not complete:

i. Identifies the information that is not accurate or not complete;

ii. Describes the circumstances that make the information not accurate or not complete;

iii. States what actions the outpatient treatment center is taking to correct the inaccurate information or make the information complete; and

iv. Attests that, to the best of the knowledge and belief of the outpatient treatment center administrator or designee, the information submitted according to subsections (B)(1) and (B)(2), except the information identified in subsection (B)(3)(b)(i), is accurate and complete.

C. An outpatient treatment center administrator shall implement rates and charges for a rates and charges schedule submitted as specified in subsection (A) or for a change in the outpatient treatment center’s current rates and charges information submitted as specified in subsection (B) on a date determined by the outpatient treatment center but not earlier than the date the Department notifies the outpatient treatment center that the Department received the rates and charges information.

D. When the Department receives from an outpatient treatment center a rates and charges schedule submitted as specified in subsection (A) or a change in the outpatient treatment center’s rates and charges information submitted as specified in subsection (B), the Department shall provide written notice to the outpatient treatment center within five business days of receipt of the rates and charges information.

E. An outpatient treatment center administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the outpatient treatment center’s current rates and charges information not prepared as specified in subsection (B), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If an outpatient treatment center administrator or designee does not submit a rates and charges schedule or information about changes to the outpatient treatment center’s rates and charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

Historical Note

Section recodified from R9-11-107 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Section repealed; new Section made by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-306. Expired

Historical Note

R9-11-307. Expired

**Historical Note**

**ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING**

Article 4, consisting of R9-11-401 and R9-11-402, made by final rulemaking at 9 A.A.R. 2105, effective June 3, 2003 (Supp. 03-2).

R9-11-401. Definitions
In this Article, unless otherwise specified:
1. “Admitting diagnosis” means the reason an individual is admitted to a hospital.
2. “DRG” means Diagnosis Related Group, a type of prospective payment system used in billing for inpatient episodes of care.
3. “HIPPS” means the Health Insurance Prospective Payment System, a type of prospective payment system used by specific health care institutions, such as rehabilitation hospitals, for billing for services provided by the health care institutions.
4. “Inpatient discharge report” means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-402.
5. “Length of stay” means the total number of calendar days for a specific episode of care, from the date of admission to the date of discharge.

**Historical Note**

R9-11-402. Reporting Requirements
A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department with the inpatient discharge report required in subsection (C):
1. The name of the hospital;
2. The hospital’s Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the inpatient discharge report;
4. If the entity submitting the inpatient discharge report to the Department is different from the hospital:
   a. The name of the entity submitting the inpatient discharge report to the Department; and
   b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the inpatient discharge report;
5. The reporting period; and
6. The name of the electronic file containing the inpatient discharge report specified in subsection (C).

B. A hospital administrator or designee shall on a form provided by the Department:
1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
2. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
   a. Identify the information that is not accurate or not complete;
   b. Describe the circumstances that make the information not accurate or not complete;
   c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
   d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.

C. A hospital administrator shall ensure that an inpatient discharge report:
1. Is prepared and named in a format specified by the Department;
2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
3. Contains the following information for each inpatient discharge that occurred during the reporting period specified in subsection (A)(5):
   a. The Arizona facility ID and national provider identifier for the hospital;
   b. A code indicating that the information submitted about the patient is for an inpatient episode of care;
   c. The patient’s medical record number;
   d. The patient’s control number;
   e. The patient’s name;
   f. The patient’s mailing address;
   g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
   h. A code indicating that the patient is homeless, if applicable;
   i. The patient’s date of birth and last four digits of the patient’s Social Security number;
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j. Codes indicating the patient’s gender, race, ethnicity, and marital status;
k. The date and a code indicating the hour the patient was admitted to the hospital;
l. A code indicating the priority of visit;
m. A code indicating the referral source;
n. The date and a code indicating the hour the patient was discharged from the hospital;
o. A code indicating the patient’s discharge status;
p. If the patient is a newborn, the patient’s birth weight in grams;
q. Whether the patient has a DNR known to the hospital;
r. The date the bill for hospital services was created;
s. The total charges billed for the episode of care;
t. A code indicating the expected payer source;
u. For each unit of service billed for the episode of care, the:
  i. Revenue code;
  ii. Charge billed; and
  iii. HIPPS code, if applicable;
v. The DRG code for the episode of care;
w. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;
x. The International Classification of Diseases codes for the patient’s admitting, principal, and secondary diagnoses;
y. If applicable, the E-codes associated with the episode of care;
z. If applicable, the state in which an accident leading to the episode of care occurred;
aa. If applicable, the date of the onset of symptoms leading to the episode of care;
b. If a procedure was performed during the episode of care:
  i. The International Classification of Diseases codes for the principal procedure and any other procedures performed during the episode of care, and
  ii. The dates the principal procedure and any other procedures were performed;
cc. The name, state license number, and, if applicable, national provider identifier of the patient’s attending provider;
dd. The code for the state licensing board that issued the license for the patient’s attending provider;
e. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient’s principal procedure, if applicable;
f. The code for the state licensing board that issued the license for the medical practitioner who performed the patient’s principal procedure, if applicable;
g. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient’s episode of care; and
hh. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(gg).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:
1. For each inpatient discharge between January 1 and June 30, the reports, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
2. For each inpatient discharge between July 1 and December 31, the reports, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of a report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:
1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

Historical Note

TABLE 1. Repealed

Historical Note
Table 1 recodified from Article 3 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Table 1 repealed by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).
ARTICLE 5. EMERGENCY DEPARTMENT DISCHARGE REPORTING

R9-11-501. Definitions
In this Article, unless otherwise specified:
1. “CPT code” means a code from Current Procedural Terminology, a HCPCS coding system used primarily to identify medical services and procedures provided by medical practitioners.
2. “Emergency department discharge report” means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-502.
3. “HCPCS” means the Healthcare Common Procedure Coding System used by a hospital for billing for hospital services or commodities provided to an outpatient as defined in A.A.C. R9-10-201.

Historical Note
Section recodified from R9-11-401 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Amended by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).

R9-11-502. Reporting Requirements
A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department as part of the emergency department discharge report required in subsection (C):
1. The name of the hospital;
2. The hospital’s Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the emergency department discharge report;
4. If the entity submitting the emergency department discharge report to the Department is different from the hospital:
   a. The name of the entity submitting the emergency department discharge report to the Department; and
   b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the emergency department discharge report;
5. The reporting period; and
6. The name of the electronic file containing the emergency department discharge report specified in subsection (C).
B. A hospital administrator or designee shall on a form provided by the Department:
1. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete; or
2. If the hospital administrator or designee has personal knowledge that the information submitted according to subsection (C) is not accurate or not complete:
   a. Identify the information that is not accurate or not complete;
   b. Describe the circumstances that make the information not accurate or not complete;
   c. State what actions the hospital is taking to correct the inaccurate information or make the information complete; and
   d. Attest that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C), except the information identified in subsection (B)(2)(a), is accurate and complete.
C. A hospital administrator shall ensure that an emergency department discharge report:
1. Is prepared and named in a format specified by the Department;
2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
3. Contains the following information for each emergency department discharge that occurred during the reporting period specified in subsection (A)(5):
   a. The Arizona facility ID and national provider identifier for the hospital;
   b. A code indicating that the information submitted about the patient is for an emergency department episode of care;
   c. The patient’s medical record number;
   d. The patient’s control number;
   e. The patient’s name;
   f. The patient’s mailing address;
   g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
   h. A code indicating that the patient is homeless, if applicable;
   i. The patient’s date of birth and last four digits of the patient’s Social Security number;
   j. Codes indicating the patient’s gender, race, ethnicity, and marital status;
   k. The date and a code indicating the hour the episode of care began;
   l. A code indicating the priority of visit;
   m. A code indicating the referral source;
   n. The date and a code indicating the hour the patient was discharged from the emergency department;
   o. A code indicating the patient’s discharge status;
   p. Whether the patient has a DNR known to the hospital;
   q. The date the patient’s bill was created;
   r. The total charges billed for the episode of care;
   s. A code indicating the expected payer source;
   t. For each unit of service billed for the episode of care, the:
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i. Revenue code;
ii. Charge billed; and
iii. HCPCS code, if applicable;

u. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;
v. The International Classification of Diseases code designating the reason for the patient initiating the episode of care;
w. The International Classification of Diseases codes for the patient’s principal and, if applicable, secondary diagnoses;
x. If applicable, the E-codes associated with the episode of care;
y. If applicable, the state in which an accident leading to the episode of care occurred;
z. If applicable, the date of the onset of symptoms leading to the episode of care;

aa. For each procedure performed during the episode of care:
   i. The applicable International Classification of Diseases, HCPCS/CPT codes for the principal procedure and any other procedures performed during the episode of care; and
   ii. The dates the principal procedure and any other procedures were performed;

bb. The name, state license number, and, if applicable, national provider identifier of the patient’s attending provider;
cc. The code for the state licensing board that issued the license for the patient’s attending provider;

dd. The name, state license number, and, if applicable, national provider identifier of the medical practitioner who performed the patient’s principal procedure, if applicable;
e. The code for the state licensing board that issued the license for the medical practitioner who performed the patient’s principal procedure, if applicable;
ff. The name, state license number, and, if applicable, national provider identifier of any other medical practitioner associated with the patient’s episode of care; and
gg. The code for the state licensing board that issued the license for each of the individuals specified in subsection (C)(3)(ff).

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:

1. For each emergency department discharge between January 1 and June 30, the report, information, and attestation statement shall be submitted after June 30 and no later than August 15; and
2. For each emergency department discharge between July 1 and December 31, the report, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of an emergency department discharge report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department’s letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department’s letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

Historical Note

Section recodified from R9-11-402 at 10 A.A.R. 3835, effective August 24, 2004 (Supp. 04-3). Amended by final rulemaking at 13 A.A.R. 3648, effective December 1, 2007 (Supp. 07-4).
36-125.04. Financial statements; uniform accounting report; exemption

A. Each licensed hospital shall submit to the department an annual financial statement prepared in accordance with generally accepted accounting principles. The statement shall be accompanied by a report of an audit by an independent certified public accountant of the financial statement conducted in accordance with generally accepted auditing standards. Each hospital shall submit the statement within one hundred twenty days of the end of its fiscal year unless the director grants an extension in writing in advance of that date.

B. If a hospital is part of a consolidated or combined group and is normally included in that group's financial statement, the hospital may submit a consolidated or combined statement if the group's statement identifies each of the group's separately licensed hospitals and nursing care institutions operating in this state. For each hospital or nursing care institution operating in this state and for each additional operating unit which accounts for five per cent or more of the consolidated or combined group's gross revenues, the statement shall include financial balances and information for that unit including a balance sheet, an income statement, a statement of changes in equity or fund balance and a statement of cash flows. This information shall be presented as "other financial information" in columnar format in the details of consolidation or combination. All other operating units of the group may be included in a single column labeled "other" provided that a footnote identifies each unit and the gross revenue associated with each unit. The financial information for each hospital included in a consolidated or combined financial statement shall reflect financial balances and information for only the hospital and shall not include nonhospital operations.

C. Each hospital, nursing care institution and hospice shall submit a uniform accounting report to the department annually that includes the following:

1. A balance sheet detailing the assets, liabilities and net worth.
2. A statement of income and expenses.
3. A statement of cash flows.
4. A copy of annual financial and statistical documents submitted to the United States department of health and human services in accordance with the requirements of title XVIII and title XIX of the social security act.
5. Utilization and staffing information and standard units of measure as prescribed by rules.

D. In place of the information required by subsection C, the director may permit a health care institution to file current cost reports and financial information that the institution files for other governmental reporting purposes, except that a health care institution shall file all information required by the Arizona health care cost containment system administration pursuant to title XVIII or XIX of the social security act. The department may require by rule the submission of additional information or schedules to supplement the alternative cost reports and financial information.

E. In addition to the information prescribed in subsection C, a hospital shall also include with its title XVIII cost report all pertinent data, separately stated, on the title XIX program and the state-only funded medical programs under the Arizona health care cost containment system. A hospital may request a one year waiver from the department if logs and financial systems need to be changed in order to comply with this subsection.

F. The department shall prescribe and furnish forms for the uniform accounting report submitted pursuant to subsection C.

G. All reports filed pursuant to this section are open to public inspection at the offices of the department. The department shall ensure that this public access to reports does not breach confidentiality of privileged medical information or privileged information on an individual's work performance or earnings.
H. If further investigation is considered necessary or desirable to verify the accuracy of information in reports filed pursuant to this section, the department may further examine records and accounts related to the reporting requirements of this section. The department shall bear the cost incurred in connection with this examination unless the department finds that the records examined are significantly deficient or incorrect, in which case the department may charge the cost of the investigation to the facility examined.

I. This section does not apply to a facility owned or operated by this state.

36-125.05. Uniform patient reporting system; statistical and demographic reports; exemption

A. The department shall prescribe and implement a uniform patient reporting system for hospital inpatient and emergency department services. The requirements imposed for this reporting system shall be substantially the same as the uniform billing requirements prescribed by the United States department of health and human services pursuant to titles XVIII and XIX of the social security act, as amended (42 United States Code sections 1395 through 1395pp), whether or not the effective date for the federal billing system is after January 31, 1984.

B. The department shall require hospitals to report inpatient statistical data designed to promote cost containment as the department determines. These data shall be derivable from the data obtained under the uniform patient reporting system prescribed by subsection A and, for all inpatient services, shall include the following:

1. The number of confinements.
2. The average length of stay.
3. The average charge per day.
4. The average charge per confinement, which is the product of the average length of stay multiplied by the average charge per day.
5. The average charge per confinement for each attending physician.

C. Each of the categories of data specified in subsection B shall be further categorized by one or more of the following methods as the department determines:

1. Discharge diagnoses.
2. Groupings of related diagnoses.
3. Groupings of diagnoses that typically have similar lengths of confinement.
4. Any other similar categories that may be determined by the department.

D. The department shall require hospital emergency departments to report outpatient service statistical data designed to promote cost containment. The department shall adopt rules establishing the procedures for reporting. These data shall be derivable from the data obtained under the uniform patient reporting system prescribed in subsection A, and shall include the following:

1. Date of service.
2. Surgical procedures.
3. Related diagnosis.
4. Charges for services.

E. The department may require hospitals and emergency departments to report other clinical and demographic data regarding patient age, sex or insurance coverage for inpatient and emergency department services.

F. The state hospital is exempt from the reporting requirements imposed by subsections B, D and E.
G. The data from the period beginning January 1 and ending June 30 of each year shall be reported on or before August 15 of that year. The data from the period beginning July 1 and ending December 31 of each year shall be reported on or before February 15 of the following year.

H. All reports filed pursuant to this section are open to public inspection at the offices of the department. The department shall ensure that this public access to reports does not breach confidentiality of privileged medical information or privileged information on an individual’s work performance or earnings.

I. If further investigation is considered necessary or desirable to verify the accuracy of information in reports submitted under this section, the department may further examine records and accounts related to the reporting requirements of this section. The department shall bear the cost incurred in connection with this examination unless the department finds that the records examined are significantly deficient or incorrect, in which case the department may charge the cost of the investigation to the facility examined.

36-136. Powers and duties of director; compensation of personnel; rules; definitions

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into.
pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. Whenever in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for no longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption
is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fund-raising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.

(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or
The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for the preservation or storage of food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparation of food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, "primitive camp and picnic grounds" means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.
13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as "the hospital consumer assessment of healthcare providers and systems".

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.

K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. For the purposes of this section:

1. "Cottage food product":
   (a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.
   (b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.
36-171. **Health care professionals workforce data repository; maintenance; rules; fee; public access**

A. The department shall establish and maintain the health care professionals workforce data repository containing the data collected and transferred to the department pursuant to title 32, chapter 32, article 5.

B. In accordance with the rules adopted pursuant to this section, the department may assist the health profession regulatory boards in complying with a standardized format and securely transferring the data collected.

C. The department shall adopt rules to:
   1. Provide procedures for the transfer of data from the health profession regulatory boards.
   2. Maintain the privacy and security of the data pursuant to section 32-3249.01.
   3. Specify the conditions and agreements to release the data consistent with paragraph 2 of this subsection.
   4. Establish a fee to provide the data in the repository to persons who request the information.

D. The data in the repository is not a public record pursuant to title 39, chapter 1, article 3, and the department may provide the data only:
   1. Subject to the conditions and agreements required by the rules adopted pursuant to this section.
   2. Without any personally identifiable information.
   3. For a fee that is not based on the intended use of the data.

36-436. **Filing and review of rates and rules as prerequisite to operation**

A. A new hospital or nursing care institution shall not engage in business within this state until there is filed a schedule of its rates and charges and rules that relate to those rates and charges with the director for the director's review. The schedules of rates and charges shall be in the form and contain information prescribed by the director.

B. The director shall adopt or establish reasonable guidelines for review of rates and charges for hospital or nursing care institutions. Those health care institutions which are classified by the director as hospitals pursuant to section 36-405, subsection B shall use the current edition of the statement on the financial requirements of health care institutions and services, as adopted by the American hospital association, or amended editions thereof if applicable, as a guide for establishing hospital rates and charges.

C. After a hospital or nursing care institution files the schedule required under subsection A of this section, the director shall promptly review the schedule within sixty days and publish information on gross charges based on that schedule.

36-436.01. **Rate schedules; printing and posting requirements; outpatient treatment centers; posting and filing requirements**

A. The schedule required under section 36-436 shall be printed in legible type and shall contain a listing of all services performed and commodities furnished for which a separate charge is made, together with the charges for each. The schedule shall plainly state all rules or regulations which may in any way change, affect or determine any part or the aggregate of the rates or charges or the value of the services or commodities covered by the schedule. Hospitals shall also include the number of times a separate charge was imposed for services performed or commodities furnished for each item listed during the twelve month period immediately prior to submission.

B. After review by the director a copy of the schedule shall be posted in a conspicuous place in the reception area of each hospital and any of the hospital's outpatient treatment centers or nursing care institutions using the schedule. Another copy also shall be kept in the reception area and be available for inspection by the public at all times upon request.
C. Licensed health care institutions classified as outpatient treatment centers and home health agencies shall file a copy of the schedule with the director before implementing those rates or charges and shall post a copy in a conspicuous area.

36-436.02. Increases of rates or charges; filing
A. A hospital or nursing care institution shall not increase any rate or charge until the proposed increase has been filed with the director and reviewed in the same manner as the schedule set forth in section 36-436.
B. A copy of any proposed reduction in any rate or charge shall be filed with the director for informational purposes prior to the effective date of such reduction.

36-436.03. Public availability of rates and charges
A home health agency, supervisory care home and a hospice shall furnish a copy of the institution’s rates and charges to the public on request.

36-2901.08. Hospital assessment
A. The director shall establish, administer and collect an assessment on hospital revenues, discharges or bed days for the purpose of funding the nonfederal share of the costs, except for costs of the services described in section 36-2907, subsection F, that are incurred beginning January 1, 2014 and that are not covered by the proposition 204 protection account established by section 36-778 and the Arizona tobacco litigation settlement fund established by section 36-2901.02 or any other monies appropriated to cover these costs, for all of the following individuals:
1. Persons who are defined as eligible pursuant to section 36-2901.07.
2. Persons who do not meet the eligibility standards described in the state plan or the section 1115 waiver that were in effect immediately before November 27, 2000, but who meet the eligibility standards described in the state plan as effective October 1, 2001.
3. Persons who are defined as eligible pursuant to section 36-2901.01 but who do not meet the eligibility standards in either section 36-2934 or the state plan in effect as of January 1, 2013.
B. The director shall adopt rules regarding the method for determining the assessment, the amount or rate of the assessment, and modifications or exemptions from the assessment. The assessment is subject to approval by the federal government to ensure that the assessment is not established or administered in a manner that causes a reduction in federal financial participation.
C. The director may establish modifications or exemptions to the assessment. In determining the modifications or exemptions, the director may consider factors including the size of the hospital, the specialty services available to patients and the geographic location of the hospital.
D. Before implementing the assessment, and thereafter if the methodology is modified, the director shall present the methodology to the joint legislative budget committee for review.
E. The administration shall not collect an assessment for costs associated with service after the effective date of any reduction of the federal medical assistance percentage established by 42 United States Code section 1396d(y) or 1396d(z) that is applicable to this state to less than eighty per cent.
F. The administration shall deposit the revenues collected pursuant to this section in the hospital assessment fund established by section 36-2901.09.
G. A hospital shall not pass the cost of the assessment on to patients or third-party payors that are liable to pay for care on a patient's behalf. As part of its financial statement submissions pursuant to section 36-125.04, a hospital shall submit to the department of health services an attestation that it has not passed on the cost of the assessment to patients or third-party payors.
H. If a hospital does not comply with this section as prescribed by the director, the director may suspend or revoke the hospital's Arizona health care cost containment system provider agreement registration. If the
hospital does not comply within one hundred eighty days after the director suspends or revokes the hospital's provider agreement, the director shall notify the director of the department of health services, who shall suspend or revoke the hospital's license pursuant to section 36-427.
State of Arizona
Senate
Fifty-fourth Legislature
First Regular Session
2019

CHAPTER 215
SENATE BILL 1096

AN ACT

AMENDING SECTIONS 32-3249 AND 32-3249.01, ARIZONA REVISED STATUTES;
AMENDING TITLE 36, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING
ARTICLE 3; AMENDING TITLE 36, CHAPTER 4, ARTICLE 1, ARIZONA REVISED
STATUTES, BY ADDING SECTION 36-405.02; RELATING TO HEALTH PROFESSIONALS.

(TEXT OF BILL BEGINS ON NEXT PAGE)
Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 32-3249, Arizona Revised Statutes, is amended to read:

32-3249. Definitions
In this article, unless the context otherwise requires:
1. "Board" means a health professional regulatory board that provides licensure, certification or registration and regulation pursuant to chapter 13, 15, 17, 19, 19.1 or 33 of this title.
2. "Database" means the health professionals workforce database that is developed from designated database information AND MAINTAINED BY THE DEPARTMENT IN THE HEALTH CARE PROFESSIONALS WORKFORCE DATA REPOSITORY ESTABLISHED PURSUANT TO TITLE 36, CHAPTER 1, ARTICLE 3.
3. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES.

4. "Designated database information":
(a) Means information that is collected by a board pursuant to section 32-3247.01.
(b) Does not include identification materials and information required to determine qualifications of an applicant for licensure, certification or registration.
4. "Director" means the director of the department of health services.

Sec. 2. Section 32-3249.01, Arizona Revised Statutes, is amended to read:

32-3249.01. Designated database information; collection; transfer; confidentiality

A. Beginning January 2, 2020, each board shall collect REQUEST from applicants for initial or renewal licensure, certification or registration OR OTHERWISE ON AN ANNUAL BASIS the designated database information prescribed in rule by the director pursuant to section 36-104, paragraph 25. EACH BOARD SHALL TRANSFER THE DESIGNATED DATABASE INFORMATION TO THE DEPARTMENT ON AN ANNUAL BASIS.
B. To protect the privacy and security of health professionals who provide information pursuant to this section, personally identifiable THE information UNIQUE TO THE DESIGNATED DATABASE THAT IS collected pursuant to this section is confidential and is not a public record pursuant to title 39, chapter 1, article 2 AND MAY BE DISTRIBUTED, REDISTRIBUTED OR TRANSFERRED ONLY PURSUANT TO SUBSECTION C OF THIS SECTION AND TITLE 36, CHAPTER 1, ARTICLE 3.

C. EACH BOARD MAY MAINTAIN AND USE BUT MAY NOT DISTRIBUTE THE DATA COLLECTED PURSUANT TO THIS SECTION THAT IS UNIQUE TO THE DESIGNATED DATABASE, EXCEPT A UNIVERSITY UNDER THE JURISDICTION OF THE ARIZONA BOARD OF REGENTS MAY REQUEST AND THE HEALTH PROFESSION REGULATORY BOARD MAY DISTRIBUTE DESIGNATED DATABASE INFORMATION COLLECTED BY THE HEALTH PROFESSION REGULATORY BOARD, INCLUDING PERSONALLY IDENTIFIABLE
INFORMATION. THE UNIVERSITY MAY REDISTRIBUTE THE DESIGNATED DATABASE INFORMATION RECEIVED FROM THE BOARD ONLY IF BOTH OF THE FOLLOWING APPLY:

1. THE DATA IS DEIDENTIFIED PURSUANT TO THE PUBLISHED STANDARDS OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

2. THE DATA IS INCORPORATED IN RESEARCH AND ANALYSIS BY THE UNIVERSITY THAT IS GENERATED USING THE DATA.

Sec. 3. Title 36, chapter 1, Arizona Revised Statutes, is amended by adding article 3, to read:

ARTICLE 3. HEALTH CARE PROFESSIONALS WORKFORCE DATA REPOSITORY

36-171. Health care professionals workforce data repository; maintenance; rules; fee; public access


B. IN ACCORDANCE WITH THE RULES ADOPTED PURSUANT TO THIS SECTION, THE DEPARTMENT MAY ASSIST THE HEALTH PROFESSION REGULATORY BOARDS IN COMPLYING WITH A STANDARDIZED FORMAT AND SECURELY TRANSFERRING THE DATA COLLECTED.

C. THE DEPARTMENT SHALL ADOPT RULES TO:

1. PROVIDE PROCEDURES FOR THE TRANSFER OF DATA FROM THE HEALTH PROFESSION REGULATORY BOARDS.

2. MAINTAIN THE PRIVACY AND SECURITY OF THE DATA PURSUANT TO SECTION 32-3249.01.

3. SPECIFY THE CONDITIONS AND AGREEMENTS TO RELEASE THE DATA CONSISTENT WITH PARAGRAPH 2 OF THIS SUBSECTION.

4. ESTABLISH A FEE TO PROVIDE THE DATA IN THE REPOSITORY TO PERSONS WHO REQUEST THE INFORMATION.

D. THE DATA IN THE REPOSITORY IS NOT A PUBLIC RECORD PURSUANT TO TITLE 39, CHAPTER 1, ARTICLE 3, AND THE DEPARTMENT MAY PROVIDE THE DATA ONLY:

1. SUBJECT TO THE CONDITIONS AND AGREEMENTS REQUIRED BY THE RULES ADOPTED PURSUANT TO THIS SECTION.

2. WITHOUT ANY PERSONALLY IDENTIFIABLE INFORMATION.

3. FOR A FEE THAT IS NOT BASED ON THE INTENDED USE OF THE DATA.

36-172. Workforce data repository fund; exemption

A. THE WORKFORCE DATA REPOSITORY FUND IS ESTABLISHED CONSISTING OF LEGISLATIVE APPROPRIATIONS, FEES COLLECTED PURSUANT TO THIS ARTICLE AND PRIVATE GIFTS, GRANTS, DONATIONS AND CONTRIBUTIONS. THE DEPARTMENT SHALL ADMINISTER THE FUND, AND MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED. MONIES IN THE FUND ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS.

B. THE DIRECTOR MAY ACCEPT AND SPEND PRIVATE GIFTS, GRANTS, DONATIONS AND CONTRIBUTIONS TO ASSIST IN CARRYING OUT THE PURPOSES OF THIS
ARTICLE. THESE MONIES DO NOT REVERT TO THE STATE GENERAL FUND AT THE END OF THE FISCAL YEAR.

36-173. Advisory committee; membership; committee termination

A. THE HEALTH CARE PROFESSIONALS WORKFORCE DATA REPOSITORY ADVISORY COMMITTEE IS ESTABLISHED TO ADVISE THE DIRECTOR REGARDING RULES AND POLICIES RELATING TO THE OPERATION OF THE HEALTH CARE PROFESSIONALS WORKFORCE DATA REPOSITORY. THE ADVISORY COMMITTEE CONSISTS OF AT LEAST FOURTEEN MEMBERS BUT NOT MORE THAN FIFTEEN MEMBERS WHO ARE APPOINTED BY THE DIRECTOR AND INCLUDES:

1. THE DIRECTOR OR THE DIRECTOR’S DESIGNEE, WHO SERVES AS THE CHAIRPERSON.
2. ONE PERSON WHO REPRESENTS EACH HEALTH PROFESSION REGULATORY BOARD THAT COLLECTS AND TRANSFERS DATA TO THE HEALTH CARE PROFESSIONALS WORKFORCE DATA REPOSITORY.
3. AT LEAST TWO PERSONS WHO REPRESENT UNIVERSITIES IN THIS STATE.
4. AT LEAST ONE PERSON WHO REPRESENTS A COMMUNITY COLLEGE IN THIS STATE.
5. AT LEAST ONE PERSON WHO REPRESENTS A HOSPITAL IN A COUNTY IN THIS STATE WITH A POPULATION OF FIVE HUNDRED THOUSAND PERSONS OR MORE.
6. AT LEAST ONE PERSON WHO REPRESENTS A HOSPITAL IN A COUNTY IN THIS STATE WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS.
7. ONE PERSON WHO IS A BEHAVIORAL HEALTH SERVICES PROVIDER.
8. ONE PERSON WHO IS AN OUTPATIENT SERVICES PROVIDER.
9. AT LEAST ONE PERSON WHO REPRESENTS A NONPROFIT ORGANIZATION THAT CONDUCTS RESEARCH AND EDUCATION RELATED TO HEALTH CARE.

B. THE ADVISORY COMMITTEE MEMBERS SHALL SERVE THREE-YEAR TERMS. MEMBERS SERVE IN A VOLUNTARY CAPACITY BUT ARE ELIGIBLE TO RECEIVE REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

C. THE ADVISORY COMMITTEE ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2027 PURSUANT TO SECTION 41-3103.

Sec. 4. Title 36, chapter 4, article 1, Arizona Revised Statutes, is amended by adding section 36-405.02, to read:

36-405.02. Behavioral health and other related health care services; employees; age; rules

THE DEPARTMENT SHALL ALLOW A PERSON WHO IS EMPLOYED AT A HEALTH CARE INSTITUTION THAT PROVIDES BEHAVIORAL HEALTH SERVICES, WHO IS NOT A LICENSED BEHAVIORAL HEALTH PROFESSIONAL AND WHO IS AT LEAST EIGHTEEN YEARS OF AGE TO PROVIDE BEHAVIORAL HEALTH OR OTHER RELATED HEALTH CARE SERVICES PURSUANT TO ALL APPLICABLE DEPARTMENT RULES. THE DIRECTOR SHALL ADOPT RULES CONSISTENT WITH THIS SECTION.
DEPARTMENT OF HEALTH SERVICES
Title 9, Chapter 13

GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 11, 2022

SUBJECT: Department of Health Services
Title 9, Chapter 13


Summary:

This regular rulemaking from the Department of Health Services relates to rules in Title 9, Chapter 13, Article 2 regarding Newborn and Infant Screening. The Department seeks to amend its rules to comply with Laws 2021, Ch. 409. Specifically, Laws 2021, Ch. 409, § 14, revised A.R.S. § 36-694 and directed the Department to adopt all of the Newborn Screening disorders included on the Recommended Uniform Screening Panel (RUSP) adopted by the Secretary of the U.S. Department of Health and Human Services, which included four additional core disorders and 26 secondary disorders.

Lastly, A.R.S. § 36-694, as revised by Laws 2021, Ch. 409, § 14, also authorized the program to establish a single program fee, by rule, to cover the expenses of operating the program. The Department further seeks to amend the rules to change from a specimen-based fee system to institute a single program fee, to be billed to the person submitting the initial specimen for a newborn or infant. The program fee of $171 will cover all the activities provided by the program. The Department will delay implementation of the new fee until November 1, 2022, to allow time for compliance with A.R.S. § 36-694(I)(1) and (2). In addition, the Department is adding the remaining two core disorders, glycogen storage disease type II (Pompe disease) and
mucopolysaccharidosis type I, as well as the 26 secondary disorders to the screening panel. The Department plans to implement testing for the two final core disorders by May 1, 2023, well before the statutorily required date of December 31, 2023, established by Laws 2021, Ch 409, § 32.

1. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   Yes, the Department cites to both general and specific statutory authority.

2. **Do the rules establish a new fee or contain a fee increase?**

   Yes, the rules establish a new single program fee of $171, pursuant to A.R.S. § 36-694, as revised by Laws 2021, Ch. 409, § 14.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   The Department did not review or rely on any study for this rulemaking.

4. **Summary of the agency’s economic impact analysis:**

   The Department anticipates that persons affected by the rulemaking include the Department; health insurance providers, including AHCCCS and third party payors; health care institutions, including hospitals and birth centers; midwives, pediatricians, and other health care providers; parents of newborns; and the general public. The Department states that Laws 2021, Ch. 409, § 14, revised A.R.S. 36-694 and directed the Department to adopt all of the newborn screening (NBS) disorders included on the Recommended Uniform Screening Panel (RUSP) adopted by the Secretary of the U.S. Department of Health and Human Services, which, as of the effective date of the statutory change included four additional core disorders and 26 secondary disorders. A.R.S. § 36-694, as revised by Laws 2021, Ch. 409, § 14, also authorizes the program to establish a single program fee, by rule, to cover the expenses of operating the program. The Department is amending the rules in an iterative process and is now revising the rules to change from a specimen-based fee system to institute a single program fee, to be billed to the person submitting the initial specimen for a newborn or infant.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**
The Department states there are no less intrusive to less costly alternatives for achieving the purpose of the rule.

6. **What are the economic impacts on stakeholders?**

The Department expects that having a program fee instead of a specimen-based fee may decrease the cost of billing, since only one bill would need to be generated per baby instead of two (one for the first specimen and another to probably a different payor for the second specimen) for the vast majority of babies. The Department estimates that AHCCCS will incur a substantial increase in costs when paying for these births under the increased rates for birth packages. The Department believes these increased costs may be partially offset by the elimination of the fee for a second specimen, as included in the current rules. AHCCCS may also receive up to a substantial benefit from the addition of the many new congenital disorders that are part of the revised screening panel.

The Department indicates that third party payers include private health insurance plans, military health care facilities, Indian Health Service and tribal health care facilities. These entities also pay for a large portion of the births in Arizona. The Department anticipates that many of these third party payors may incur a substantial increase in costs when paying for these births under the increased rates for birth packages. The Department believes these increased costs may again be partially offset by the elimination of the fee for a second specimen, as included in the current rules. Third party payors may also receive up to a substantial benefit from the addition of the many new congenital disorders that are part of the revised screening panel, which will allow for targeted diagnostic testing for a disorder and the cost of testing and potentially reduce the costs of the disorder.

The Department believes that health care institutions may also be affected by the rulemaking. Most first specimens are collected from a newborn before the newborn is 72 hours old and thus, would be collected by the facility at which the birth occurred, most likely a hospital or birth center. Because of the difference in the fee for a first specimen compared to the program fee, these hospitals and birth centers may incur up to a substantial increase in costs, depending on the number of births at the facility and, therefore, the number of initial specimens submitted. If a hospital, outpatient treatment center, or other health care institution is authorized to provide services needed to diagnose or treat a baby affected by one of the disorders added through rulemaking, the health care institution may incur a moderate-to-substantial decrease in revenue if an affected baby is identified through NBS and avoids multiple diagnostic tests/procedures to determine a diagnosis, extensive treatment, to address these effects of disease progression, or more expensive treatment once the disorder has become symptomatic. The health care institution may also receive a moderate-to-substantial increase in revenue from providing on-going, but likely less expensive, treatment to an affected baby/child who might otherwise have died, as well as receiving a significant benefit in
knowing that a baby, who was identified through NBS and who has been treated and/or cured, is healthy.

The Department also indicates that a parent paying a healthcare facility of a health care provider for the delivery of the newborn would likely have the fee for newborn and infant screening included in the fee charged by the health care facility or health care provider for the delivery. The Department believes the parent may also incur an increase in the premium paid to a third party payor that passes the increased newborn screening program fee on to policyholders. The Department expects the increased cost to an individual parent to be at most minimal, either directly from the fee change or indirectly through an increase in health insurance premium. The Department also anticipates that a parent of a baby with a positive result, or of a baby affected with an added disorder or condition, may receive a significant and perhaps substantial benefit from having the condition diagnosed early, through targeted testing, rather than undergo months of stress, have the baby undergo a multitude of tests to try to obtain a diagnosis, and experience the monetary and emotional toll of having a sick child.

The Department believes that society in general is expected to receive a significant benefit from having a baby grow up into a healthy and productive member of society because of timely identification and treatment of a disorder detected through newborn screening program.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department indicates they added a delayed implementation date to R9-13-203(A)(6)(f) and (g), and R9-13-208 in the Notice of Final Rulemaking. Council staff does not find the changes to be a substantial change, considered as a whole, from the proposed rules.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

The Department indicates they did not receive any comments on the proposed rules.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require the issuance of a permit or license.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws to the rules.
11. **Conclusion**

As mentioned above, the Department seeks to amend its rules to comply with recently enacted legislation (Laws 2021, Ch. 409, § 14), which amended A.R.S. § 36-694. The Department is seeking an immediate effective for the rules to better protect the health and safety of babies born in Arizona. Council staff finds the Department meets the requirements for an immediate effective date pursuant to A.R.S. § 41-1032(A)(1) and (4).

Council staff recommends approval of this rulemaking.
July 19, 2022

VIA EMAIL: grrc@azdoh.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
Arizona Department of Administration
100 N. 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Department of Health Services, 9 A.A.C. 13, Article 2, Regular Rulemaking

Dear Ms. Sornsin:

1. **The close of record date:** July 18, 2022

2. **Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:**
The rulemaking for 9 A.A.C. does not relate to a five-year-review report.

3. **Whether the rulemaking establishes a new fee and, if so, the statute authorizing the fee:**
The rulemaking does establish a new program fee, authorized by A.R.S. § 36-694.

4. **Whether the rulemaking contains a fee increase:**
The new fee in the rulemaking constitutes a fee increase.

5. **Whether an immediate effective date is requested pursuant to A.R.S. 41-1032:**
Yes, the Department is requesting an immediate effective date for the rules to protect the health and safety of newborns, pursuant to A.R.S. 41-1032(1) and (4).

The Department is requesting that the rules be heard at the Council meeting on September 7, 2022.

The Department certifies that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on in its evaluation of or justification for the rule.

The Department certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:
a. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of the rule;
b. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;
c. Current rules; and
d. General and specific statutes authorizing the rules.

The Department’s point of contact for questions about the rulemaking documents is Ruthann Smejkal at Ruthann.Smejkal@azdhs.gov.

Sincerely,

Robert Lane
Director's Designee

RL: rms

Enclosures
NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 13. DEPARTMENT OF HEALTH SERVICES
HEALTH PROGRAMS SERVICES

PREAMBLE

1. Article, Part, or Section Affected (as applicable)  Rulemaking Action
   R9-13-201         Amend
   R9-13-203         Amend
   R9-13-208         Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):
   Authorizing statutes: A.R.S. §§ 36-132(A), 36-136(A)(7), and 36-136(F)
   Implementing statutes: A.R.S. § 36-694, as amended by Laws 2021, Ch. 409

3. The effective date of the rules:
   According to A.R.S. § 41-1032(A)(1) and (4), the Arizona Department of Health Services (Department) requests an immediate effective date for the rules to better protect the health and safety of babies born in Arizona as soon as possible.

4. 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: 27 A.A.R. 1334, August 27 2021
   Notice of Proposed Expedited Rulemaking: 27 A.A.R. 1417, September 10, 2021
   Notice of Final Expedited Rulemaking: 28 A.A.R. 226, January 21, 2022
   Notice of Proposed Rulemaking: 28 A.A.R. 1389, June 17, 2022

5. The agency's contact person who can answer questions about the rulemaking:
   Name: Ward Jacox, Assistant Bureau Chief
   Address: Arizona Department of Health Services
            Office of Newborn Screening
            250 N. 17th Avenue
            Phoenix, AZ 85007
   Telephone: (602) 364-1410
   Fax: (602) 364-1495
   E-mail: Ward.Jacox@azdhs.gov
   or
Name: Stephanie Elzenga, Interim Chief
Address: Arizona Department of Health Services
Office of Administrative Counsel and Rules
150 N. 18th Ave., Suite 200
Phoenix, AZ  85007
Telephone:  (602) 542-1020
Fax: (602) 364-1150
E-mail: Stephanie.Elzenga@azdhs.gov

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

   Arizona Revised Statutes (A.R.S.) § 36-694 contains requirements for ordering tests for certain congenital disorders and reporting congenital disorder test results and hearing test results to the Department, and establishes a newborn screening program, a central database for information about newborns and infants who are tested for congenital disorders or hearing loss, an educational program and follow-up services, and a newborn screening program committee. Current rules in Arizona Administrative Code (A.A.C.) Title 9, Chapter 13, Article 2, specify the congenital disorders being tested for, the information required when critical congenital heart defect screening is performed, the information required when a bloodspot specimen is collected from a newborn or infant, the person responsible for collecting the specimen, when the specimen should be collected, reporting requirements for a bloodspot test, reporting requirements for hearing tests, and fees. Laws 2021, Ch. 409, § 14, revised A.R.S. § 36-694 and directed the Department to adopt all of the NBS disorders included on the Recommended Uniform Screening Panel (RUSP) adopted by the Secretary of the U.S. Department of Health and Human Services, which, as of the effective date of the statutory change, included four additional core disorders and 26 secondary disorders (see Appendix A). A.R.S. § 36-694, as revised by Laws 2021, Ch. 409, § 14, also authorizes the program to establish a single program fee, by rule, to cover the expenses of operating the program. After obtaining an exception from the rulemaking moratorium established by Executive Order 2021-02, the Department is amending the rules in 9 A.A.C. 13, Article 2 to comply with Laws 2021, Ch. 409 in an iterative process.

   As required by Laws 2021, Ch 409, § 32, the Department has added, through expedited rulemaking, two of the core disorders, spinal muscular atrophy and x-linked adrenoleukodystrophy, to the congenital disorders being tested for, effective December 30, 2021. Now, the Department is further revising the rules to change from a specimen-based fee system to institute a single program fee, to be billed to the person submitting the initial specimen for a
newborn or infant. The program fee will cover all the activities provided by the program. The Department will delay implementation of the new fee until November 1, 2022, to allow time for compliance with A.R.S. § 36-694(I)(1) and (2). In addition, the Department is adding the remaining two core disorders, glycogen storage disease type II (Pompe disease) and mucopolysaccharidosis type I, as well as the 26 secondary disorders to the screening panel. The Department plans to implement testing for the two final core disorders by May 1, 2023, well before the statutorily required date of December 31, 2023, established by Laws 2021, Ch 409, § 32.

7. **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 Department did not review or rely on any study for this rulemaking.

8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable

9. **A summary of the economic, small business, and consumer impact:**
   The Department anticipates that persons affected by the rulemaking include the Department; health insurance providers, including AHCCCS and third-party payors; health care institutions, including hospitals and birth centers; midwives, pediatricians, and other health care providers; parents of newborns; and the general public. Annual cost/revenue changes are designated as minimal when $2,700 or less, moderate when between $2,700 and $27,000, and substantial when $27,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification.

   The Department expects to receive a substantial benefit from the change from a specimen-based fee system to a newborn screening program fee and from the increase in the overall fee. The program fee, which will cover all aspects of the program, will allow the Department to adequately perform the activities currently undertaken by the program, as well as add testing and follow-up for the additional disorders included on the RUSP. Having a program fee instead of a specimen-based fee may also decrease the costs of billing, since only one bill would need to be generated per baby instead of two (one for the first specimen and another to probably a different payor for the second specimen) for the vast majority of babies. The Department anticipates
receiving a significant benefit from being able to identify affected babies earlier to enable them to have healthier lives.

AHCCCS is required by A.R.S. § 36-694(I)(2) to update the rates included in birth packages to reflect the fee increase. Because AHCCCS is the payor for almost half of births in Arizona, the Department estimates that AHCCCS will incur a substantial increase in costs when paying for these births under the increased rates for the birth packages. These increased costs may be partially offset by the elimination of the fee for a second specimen, as is included in the current rules. AHCCCS may also receive up to a substantial benefit from the addition of the many new congenital disorders that are part of the revised screening panel. With newborn screening, these disorders can be identified and treated early, improving outcomes. A positive screening result also allows targeted diagnostic testing for a disorder, reducing the number of tests before a diagnosis is made and the costs of these tests. The costs to treat the disorder are also generally less with an early diagnosis.

Third-party payors include private insurance plans, military health care facilities, Indian Health Service, and tribal health care facilities. These entities also pay for a large proportion of births in Arizona. The Department anticipates that many of these third-party payors may incur up to a substantial increase in costs when paying for these births under the increased rates required by A.R.S. § 36-694(I)(1) to be included in birth packages. These increased costs may again be partially offset by the elimination of the fee for a second specimen. Third-party payors may also receive up to a substantial benefit from the addition of the many new congenital disorders that are part of the revised screening panel, which will allow targeted diagnostic testing for a disorder and the costs of testing and potentially reduce the costs to treat the disorder.

The Department believes that health care institutions may also be affected by the rulemaking. Most first specimens are collected from a newborn before the newborn is 72 hours old and thus, would be collected by the facility at which the birth occurred, most likely a hospital or birth center. These facilities would be the ones submitting the initial specimen, as defined in R9-13-201, and would be billed the newborn screening program fee. Because of the difference in the fee for a first specimen compared with the program fee, these hospitals and birth centers may incur up to a substantial increase in costs, depending on the number of births at the facility and, therefore, the number of initial specimens submitted. This increase may be offset by the increase in birth packages required under A.R.S. § 36-694(I)(1) and (2), and further mitigated by the delayed implementation of the new fee until November 1, 2022. If a hospital, outpatient treatment center, or other health care institution is authorized to provide services needed to diagnose or treat a baby affected with one of the disorders added through the rulemaking, the health care institution
may incur a moderate-to-substantial decrease in revenue if an affected baby is identified through NBS and avoids multiple diagnostic tests/procedures to determine a diagnosis, extensive treatment to address the effects of disease progression, or more expensive treatment once the disorder has become symptomatic. The health care institution may also receive a moderate-to-substantial increase in revenue from providing on-going, but likely less expensive, treatment to an affected baby/child, who might otherwise have died, as well as receive a significant benefit in knowing that a baby, who was identified through NBS and who has been treated and/or cured, is healthy.

Health care providers that may be affected by the rule changes include midwives, pediatricians, and primary care providers. Midwives as a whole submit fewer than 300 first specimens per year for the newborns they deliver from their clients and are the only health care providers who have submitted first specimens, according to Department records. If a similar number of initial specimens is submitted by midwives in upcoming years, the Department would expect midwives as a whole to incur a substantial increase in costs due to the rulemaking. The cost to an individual midwife is estimated to range from minimal-to-moderate, depending on the number of initial specimens submitted. If a baby does not have a first specimen collected, an unlinked second specimen would be considered an initial specimen and the program fee would be billed to the submitter of this specimen, likely a pediatrician or primary care provider. Thus, the Department believes that these health care providers may incur at most a minimal increase in costs due to the rulemaking. All health care providers would be expected to receive a significant benefit from knowing that an affected baby, identified through NBS, treated, and cured, is healthy.

A parent paying a health care facility or health care provider for the delivery of the newborn would likely have the fee for newborn and infant screening included in the fee charged by the health care facility or health care provider for the delivery. A parent may also incur an increase in the premium paid to a third-party payor that passes the increased newborn screening program fee on to policyholders. The Department expects that the increased cost to an individual parent to be at most minimal, either directly from the fee change or indirectly through an increase in a health insurance premium. The Department also anticipates that a parent of a baby with a positive result, or of a baby affected with an added disorder or another condition, may receive a significant and perhaps up to a substantial benefit from having the condition diagnosed early, through targeted testing, rather than undergo months of stress, have the baby undergo a multitude of tests to try to obtain a diagnosis, and experience the monetary and emotional toll of having a sick child.
Society in general is expected to receive a significant benefit from having a baby grow up into a healthy and productive member of society because of timely identification and treatment of a disorder detected through the newborn screening program.

10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

   Between the proposed rulemaking and final rulemaking, the Department made the following changes to the rules:
   - In R9-13-203(A)(6)(f) and (g), added a delayed implementation date to begin testing for two disorders. To enable the Department to begin testing for these two disorders, the Department will need the funding provided by the new program fee, as well as additional time to develop the expertise in performing the testing to ensure accurate results.
   - In R9-13-208, added a delayed implementation date to begin collecting the new fee. The additional time before implementation of the new fee will allow time for stakeholder compliance with the requirements in A.R.S. § 36-694(I)(1) and (2), as amended by Laws 2021, Ch. 409, so as not to impose a burden on the submitters of initial specimens before hospital rates are updated. The Department does not believe these are substantive changes to the rules, just staggering their implementation to reduce stakeholder burdens and better protect health and safety.

11. **An agency’s summary of the public stakeholder comments made about the rulemaking and the agency response to the comments:**

   During the formal public comment period, the Department received no written comments about the rules and no members of the public attended the oral proceeding held on July 18, 2022, either in person or through teleconferencing.

12. **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:**

   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.

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

      Not applicable
c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No business competitiveness analysis was received by the Department.

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

Not applicable

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:
TITLE 9. HEALTH SERVICES
CHAPTER 13. DEPARTMENT OF HEALTH SERVICES
HEALTH PROGRAM SERVICES
ARTICLE 2. NEWBORN AND INFANT SCREENING

Section
R9-13-201. Definitions
R9-13-203. Newborn and Infant Bloodspot Tests
R9-13-208. Fees Newborn Screening Program Fee
R9-13-201. Definitions

In this Article, unless otherwise specified:

1. “Abnormal result” means an outcome that deviates from the range of values established by:
   a. The Department for an analysis performed as part of a bloodspot test or for a hearing test, or
   b. A health care facility or health care provider for critical congenital heart defect screening.

2. “Admission” or “admitted” means the same as in A.A.C. R9-10-101.


4. “Amino acid disorder” means a congenital disorder characterized by the abnormal accumulation of an amino acid or another nitrogen-containing molecule due to a defective enzyme.

5. “Argininosuccinic acidemia” means a congenital disorder characterized by an inability to metabolize the amino acid argininosuccinic acid due to defective argininosuccinate lyase activity.

6. “Arizona State Laboratory” means the entity operated according to A.R.S. § 36-251.

7. “Audiological equipment” means an instrument used to help determine the presence, type, or degree of hearing loss by:
   a. Providing ear-specific and frequency-specific stimuli to an individual; or
   b. Measuring an individual’s physiological response to stimuli.

8. “Audiologist” means the same as in A.R.S. § 36-1901.

9. “Beta-ketothiolase deficiency” means a congenital disorder characterized by an inability to metabolize 2-methyl-acetoacetyl-CoA due to defective mitochondrial acetoacetyl-CoA thiolase activity.

10. “Biotinidase deficiency” means a congenital disorder characterized by defective biotinidase activity that causes abnormal biotin metabolism.

11. “Birth center” means a health care facility that is not a hospital and is organized for the purpose of delivering newborns.

12. “Blood sample” means capillary or venous blood, and possibly arterial blood but not cord blood, applied to the filter paper of a specimen collection kit.

13. “Bloodspot test” means multiple laboratory analyses performed on a blood sample to screen for the presence of congenital disorders listed in R9-13-203.
13. “Carnitine uptake defect” means a congenital disorder characterized by a decrease in the amount of free carnitine due to defective sodium ion-dependent carnitine transporter OCTN2 activity.

14. “Citrullinemia” means a congenital disorder characterized by an inability to convert the amino acid citrulline and aspartic acid into argininosuccinic acid due to defective argininosuccinate synthetase activity.

15. “Classic galactosemia” means a congenital disorder characterized by abnormal galactose metabolism due to defective galactose-1-phosphate uridylyltransferase activity.

16. “Congenital adrenal hyperplasia” means a congenital disorder characterized by decreased cortisol production and increased androgen production due to defective 21-hydroxylase activity.

17. “Congenital disorder” means an abnormal condition present at birth, as a result of heredity or environmental factors, that impairs normal physiological functioning of a human body.

18. “Congenital hypothyroidism” means a congenital disorder characterized by deficient thyroid hormone production.

19. “Critical congenital heart defect” means a heart abnormality or condition present at birth that places a newborn or infant at significant risk of disability or death if not diagnosed soon after birth.

20. “Cystic fibrosis” means a congenital disorder caused by defective functioning of a transmembrane regulator protein and characterized by damage to and dysfunction of various organs, such as the lungs, pancreas, and reproductive organs.


22. “Diagnostic evaluation” means a hearing test performed by an audiologist or a physician to determine whether hearing loss exists, and, if applicable, determine the type or degree of hearing loss.

23. “Discharge” means the termination of inpatient services to a newborn or an infant.

24. “Disorder” means a disease or medical condition that may be identified by a laboratory analysis.

25. “Document” means to establish and maintain information in written, photographic, electronic, or other permanent form.

26. “Educational materials” means printed or electronic information provided by the Department, explaining newborn and infant screening, any of the congenital disorders listed in R9-13-203, hearing loss, or critical congenital heart defect.
27.19. “Electronic” means the same as in A.R.S. § 44-7002.

20. “Endocrine disorder” means a congenital disorder characterized by an abnormal amount of a hormone being secreted from a gland into the blood stream.

21. “Fatty acid oxidation disorder” means a congenital disorder characterized by the inability of the body to break down fatty acids as a source of energy.

28-22. “First specimen” means the initial specimen that is collected from a newborn who is less than five days of age and sent to the Arizona State Laboratory for testing and recording of demographic information.

29. “Glutaric acidemia type I” means a congenital disorder characterized by an accumulation of glutaric acid due to defective glutaryl-CoA dehydrogenase activity.

30-23. “Guardian” means an individual appointed by a court under A.R.S. Title 14, Chapter 5, Article 2.

31-24. “Health care facility” means a health care institution, as defined in A.R.S. § 36-401, where obstetrical care or newborn care is provided.

32-25. “Health care provider” means a physician, physician assistant, registered nurse practitioner, or midwife.

33-26. “Health-related services” means the same as in A.R.S. § 36-401.

34-27. “Hearing screening” means a hearing test to determine the likelihood of hearing loss in a newborn or infant.

35-28. “Hearing test” means an evaluation of each of a newborn’s or an infant’s ears, using audiological equipment to:
   a. Screen the newborn or infant for a possible hearing loss;
   b. Determine that the newborn or infant does not have a hearing loss; or
   c. Diagnose a hearing loss in the newborn or infant, including determining the type or degree of hearing loss.

36. “Hemoglobin S/Beta-thalassemia” means a sickle cell disease in which an individual has one sickle cell gene and one gene for beta thalassemia, another inherited hemoglobinopathy.

37. “Hemoglobin S/C disease” means a sickle cell disease in which an individual has one sickle cell gene and one gene for another inherited hemoglobinopathy called hemoglobin C.

38-29. “Hemoglobinopathy” means a congenital disorder characterized by abnormal production, structure, or functioning of hemoglobin.
39.30. “Home birth” means delivery of a newborn, outside a health care facility, when the newborn is not hospitalized within 72 hours of delivery.

40. “Homocystinuria” means a congenital disorder characterized by abnormal methionine and homocysteine metabolism due to defective cystathione-β-synthase activity.

41.31. “Hospital” means the same as in A.A.C. R9-10-101.

42.32. “Hospital services” means the same as in A.A.C. R9-10-201.

43. “3-Hydroxy-3-methylglutaric aciduria” means a congenital disorder characterized by the accumulation of 3-hydroxy-3-methylglutaric acid due to a defective 3-hydroxy-3-methylglutaryl-CoA lyase activity.

44.33. “Identification code” means a unique set of numbers or letters, or a unique set of both numbers and letters, assigned by the Department to a health care facility, a health care provider, an audiologist, or another person submitting specimen collection kits to the Arizona State Laboratory or hearing test results to the Department.

45.34. “Infant” means the same as in A.R.S. § 36-694.

46.35. “Initial specimen” means the earliest specimen that was collected from a newborn or infant and sent to the Arizona State Laboratory for testing.

47.36. “Inpatient” means an individual who:
   a. Is admitted to a hospital,
   b. Receives hospital services for 24 consecutive hours, or
   c. Is admitted to a birth center.

48.37. “Inpatient services” means medical services, nursing services, or other health-related services provided to an inpatient in a health care facility.

49. “Isovaleric acidemia” means a congenital disorder characterized by an accumulation of isovaleric acid due to defective isovaleryl-CoA dehydrogenase activity.

50. “Long-chain 3-hydroxy acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 16 carbon atoms in length due to defective long-chain 3-hydroxy acyl-CoA dehydrogenase activity.

51.38. “Medical services” means the same as in A.R.S. § 36-401.

52. “Medium chain acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 6 to 10 carbon atoms in length due to defective medium-chain acyl-CoA dehydrogenase activity.
“3-Methylcrotonyl-CoA carboxylase deficiency” means a congenital disorder characterized by an accumulation of 3-methylcrotonyl-glycine due to defective 3-methylcrotonyl-CoA carboxylase activity.

“Methylmalonic acidemia (Cbl A,B)” means a congenital disorder characterized by an accumulation of methylmalonic acid due to defective activity of methylmalonyl-CoA racemase or adenosylcobalamin synthetase.

“Methylmalonic acidemia (mutase deficiency)” means a congenital disorder characterized by an accumulation of methylmalonic acid due to defective methylmalonyl-CoA mutase activity.

“Midwife” means an individual licensed under A.R.S. Title 36, Chapter 6, Article 7, or certified under A.R.S. Title 32, Chapter 15.

“Multiple carboxylase deficiency” means a congenital disorder characterized by an inability to transport or metabolize biotin that leads to defective activity of propionyl-CoA carboxylase, beta-methylcrotonyl-CoA carboxylase, and pyruvate carboxylase.

“Newborn” means the same as in A.R.S. § 36-694.

“Newborn care” means medical services, nursing services, and health-related services provided to a newborn.

“Nursing services” means the same as in A.R.S. § 36-401.

“Obstetrical care” means medical services, nursing services, and health-related services provided to a woman throughout her pregnancy, labor, delivery, and postpartum.

“Organ” means a somewhat independent part of a human body, such as a salivary gland, kidney, or pancreas, which performs a specific function.

“Organic acid disorder” means a congenital disorder characterized by the abnormal accumulation of organic acids in the blood and urine due to a defective enzyme.

“Parent” means a natural, adoptive, or custodial mother or father of a newborn or an infant.

“Parenteral nutrition” means the feeding of an individual intravenously through the administration of a formula containing at least glucose, and amino acids, as well as possibly lipids, vitamins, and minerals.

“Person” means the state, a municipality, district, or other political subdivision, a cooperative, institution, corporation, company, firm, partnership, individual, or other legal entity.

“Phenylketonuria” means a congenital disorder characterized by abnormal phenylalanine metabolism due to defective phenylalanine hydroxylase activity.
“Physician” means an individual licensed under A.R.S. Title 32, Chapters 13, 14, 17, or 29.

“Physician assistant” means an individual licensed under A.R.S. Title 32, Chapter 25.

“Propionic acidemia” means a congenital disorder characterized by an accumulation of glycine and 3-hydroxypropionic acid due to defective propionyl-CoA carboxylase activity.

“Pulse oximetry” means a non-invasive method of measuring the percentage of hemoglobin in the blood that is saturated with oxygen using a device approved by the U.S. Food and Drug Administration for use with newborns or infants less than six weeks of age.

“Registered nurse practitioner” means the same as in A.R.S. § 32-1601.

“Second specimen” means a specimen that is sent to the Arizona State Laboratory for testing and recording of demographic information, after being collected:
   a. From a newborn after a first specimen; or
   b. From from an individual who is at least five days and not older than one year of age, regardless of whether a first specimen was collected.

“Severe combined immunodeficiency” means a congenital disorder usually characterized by a defect in both the T- and B-lymphocyte systems, which typically results in the onset of one or more serious infections within the first few months of life.

“Sickle cell anemia” means a sickle cell disease in which an individual has two sickle cell genes.

“Sickle cell disease” means a hemoglobinopathy characterized by an abnormally shaped red blood cell resulting from the abnormal structure of the protein hemoglobin.

“Sickle cell gene” means a unit of inheritance that is involved in producing an abnormal type of the protein hemoglobin, in which the amino acid valine is substituted for the amino acid glutamic acid at a specific location in the hemoglobin.

“Specimen” means a blood sample obtained from and demographic information about a newborn or an infant.

“Specimen collection kit” means a strip of filter paper for collecting a blood sample attached to a form for obtaining the information specified in R9-13-203(B)(3) about a newborn or an infant.

"Spinal muscular atrophy “ means a congenital disorder characterized by the loss of nerve cells in the spinal cord that control muscle movement due to the deletion of exon 7 in the survival motor neuron 1 (SMN1) gene.
80.58. “Transfer” means a health care facility or health care provider discharging a newborn and sending the newborn to a hospital for inpatient medical services without the intent that the patient will be returned to the sending health care facility or health care provider.

81.59. “Transfusion” means the infusion of blood or blood products into the body of an individual.

82. “Trifunctional protein deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 18 carbon atoms in length due to defective mitochondrial trifunctional protein activity.

83. “Tyrosinemia type I” means a congenital disorder characterized by an accumulation of the amino acid tyrosine due to defective fumarylacetoacetate hydrolase activity.

84.60. “Verify” means to confirm by obtaining information through a source such as the newborn screening program, a health care provider, a health care facility, or a documented record.

85. “Very long-chain acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 14 to 18 carbon atoms in length due to defective very long-chain acyl-CoA dehydrogenase activity.

86.61. “Working day” means 8:00 a.m. through 5:00 p.m. Monday through Friday, excluding state holidays.

87. “X-linked adrenoleukodystrophy” means a congenital disorder characterized by the build-up in the body of very long-chain fatty acids due to a deficiency in the amount of adrenoleukodystrophy protein, caused by a defective ABCD1 gene.

R9-13-203. Newborn and Infant Bloodspot Tests

A. A bloodspot test shall screen for the following congenital disorders:

1. 3-Hydroxy-3-methylglutaric aciduria,
2. 3-Methylcrotonyl-CoA carboxylase deficiency,
3. Argininosuccinic acidemia,
4. Beta-ketothiolase deficiency,
5. Biotinidase deficiency,
6. Carnitine uptake defect,
7. Citrullinemia,
8. Classic galactosemia,
9. Congenital adrenal hyperplasia,
10. Congenital hypothyroidism,
Cystic fibrosis,
Glutaric acidemia type I,
Hemoglobin S/Beta-thalassemia,
Hemoglobin S/C disease,
Homoeystinuria,
Isovaleric acidemia,
Long-chain 3-hydroxy acyl-CoA dehydrogenase deficiency,
Maple syrup urine disease,
Medium chain acyl-CoA dehydrogenase deficiency,
Methylmalonic acidemia (Cbl A,B),
Methylmalonic acidemia (mutase deficiency),
Multiple carboxylase deficiency,
Phenylketonuria,
Propionic acidemia,
Severe combined immunodeficiency,
Sickle cell anemia,
Spinal muscular atrophy,
Trifunctional protein deficiency,
Tyrosinemia type I,
Very long chain acyl-CoA dehydrogenase deficiency, and
X-linked adrenoleukodystrophy.

Amino acid disorders, including:

a. Argininemia, a congenital disorder characterized by an inability to metabolize the amino acid arginine due to defective arginase activity;
b. Argininosuccinic acidemia, a congenital disorder characterized by an inability to metabolize the amino acid argininosuccinic acid due to defective argininosuccinate lyase activity;
c. Biopterin defect in cofactor biosynthesis, a congenital disorder characterized by reduced levels of tetrahydrobiopterin due to a defect in an enzyme that produces tetrahydrobiopterin;
d. Biopterin defect in cofactor regeneration, a congenital disorder characterized by reduced levels of tetrahydrobiopterin due to a defect in an enzyme that recycles tetrahydrobiopterin to a usable form after a metabolic reaction;
e. Citrullinemia type I, a congenital disorder characterized by an inability to convert the amino acid citrulline and aspartic acid into argininosuccinic acid due to defective argininosuccinate synthetase activity;

f. Citrullinemia type II, a congenital disorder characterized by a reduction in levels of citrin, which is involved in the transport of glutamate and aspartate, due to a defective SLC25A13 gene;

g. Homocystinuria, a congenital disorder characterized by abnormal methionine and homocysteine metabolism due to defective cystathione-β-synthase activity;

h. Hypermethioninemia, a congenital disorder characterized by an elevated level of methionine in the bloodstream;

i. Hyperphenylalaninemia (benign), a congenital disorder characterized by an elevated level of phenylalanine in the bloodstream with few, if any, clinical symptoms;

j. Maple syrup urine disease, a congenital disorder of branched chain amino acid metabolism due to defective branched chain-keto acid dehydrogenase activity;

k. Phenylketonuria, a congenital disorder characterized by abnormal phenylalanine metabolism due to defective phenylalanine hydroxylase activity;

l. Tyrosinemia type I, a congenital disorder characterized by an accumulation of the amino acid tyrosine due to defective fumarylacetoacetate hydrolase activity;

m. Tyrosinemia type II, a congenital disorder characterized by an accumulation of the amino acid tyrosine due to defective tyrosine aminotransferase activity; and

n. Tyrosinemia type III, a congenital disorder characterized by an accumulation of the amino acid tyrosine and metabolic product 4-hydroxyphenylpyruvate due to defective 4-hydroxyphenylpyruvate dioxygenase activity;

2. Endocrine disorders, including:

a. Congenital adrenal hyperplasia, a congenital disorder characterized by decreased cortisol production and increased androgen production due to defective 21-hydroxylase activity; and

b. Congenital hypothyroidism, a congenital disorder characterized by deficient thyroid hormone production;

3. Fatty acid oxidation disorders, including:

a. 2,4 Dienoyl-CoA reductase deficiency, a congenital disorder characterized by an accumulation of the amino acid lysine and some fatty acids due to defective 2,4 dienoyl-CoA reductase activity;
b. Carnitine shuttle disorders, including:
   i. Carnitine palmitoyltransferase I deficiency, a congenital disorder characterized by the defective activity of carnitine palmitoyltransferase I, resulting in the inability of a cell to transport carnitine and acyl-CoA out of the cytosol;
   ii. Carnitine-acylcarnitine translocase deficiency, a congenital disorder characterized by the defective activity of carnitine-acylcarnitine translocase, resulting in the inability of acylcarnitine to enter the mitochondria; and
   iii. Carnitine palmitoyltransferase II deficiency, a congenital disorder characterized by the defective activity of carnitine palmitoyltransferase II, resulting in the inability to transfer acyl-CoA into the mitochondria;

c. Carnitine uptake defect, a congenital disorder characterized by a decrease in the amount of free carnitine due to defective sodium ion-dependent carnitine transporter OCTN2 activity;

d. Glutaric acidemia type II, a congenital disorder characterized by a decrease in the ability to break down proteins and fatty acids due to decreased activity of either electron transfer flavoprotein or electron transfer flavoprotein dehydrogenase;

e. Long-chain 3-hydroxy acyl-CoA dehydrogenase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 18 carbon atoms in length due to defective long-chain 3-hydroxy acyl-CoA dehydrogenase activity;

f. Medium-chain acyl-CoA dehydrogenase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 6 to 10 carbon atoms in length due to defective medium-chain acyl-CoA dehydrogenase activity;

g. Medium-chain ketoacyl-CoA thiolase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids due to defective ketoacyl-CoA thiolase activity;

h. Medium/short chain L-3 hydroxyacyl-CoA dehydrogenase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 3 to 10 carbon atoms in length due to defective 3-hydroxyacyl-CoA dehydrogenase activity;
i. Short chain acyl-CoA dehydrogenase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 6 or fewer carbon atoms in length due to defective short chain acyl-CoA dehydrogenase activity;

j. Trifunctional protein deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 18 carbon atoms in length due to defective mitochondrial trifunctional protein activity; and

k. Very long-chain acyl-CoA dehydrogenase deficiency, a congenital disorder characterized by an inability to metabolize fatty acids that are 14 to 18 carbon atoms in length due to defective very long-chain acyl-CoA dehydrogenase activity;

4. Hemoglobinopathies, including:

a. Hemoglobin S/Beta-thalassemia, a sickle cell disease in which an individual has one sickle cell gene and one gene for beta thalassemia, another inherited hemoglobinopathy;

b. Hemoglobin S/C disease, a sickle cell disease in which an individual has one sickle cell gene and one gene for another inherited hemoglobinopathy called hemoglobin C;

c. Sickle cell anemia, a sickle cell disease in which an individual has two sickle cell genes; and

d. Other congenital disorders caused by an abnormal hemoglobin protein;

5. Organic acid disorders, including:

a. 2-Methylbutrylglycinuria, a congenital disorder characterized by an inability to metabolize the amino acid isoleucine, resulting in elevated levels of 2-methylbutryl carnitine, due to defective short/branched chain acyl-CoA dehydrogenase activity;

b. 2-Methyl-3-hydroxybutyric aciduria or HSD10 disease, a congenital disorder characterized by elevated levels of break-down products of the amino acid isoleucine and a reduction in functional mitochondrial tRNA molecules, which results in impaired mitochondrial synthesis of proteins;

c. 3-Hydroxy-3-methylglutaric aciduria, a congenital disorder characterized by the accumulation of 3-hydroxy-3-methylglutaric acid due to defective 3-hydroxy-3-methylglutaryl-CoA lyase activity;
d. 3-Methylcrotonyl-CoA carboxylase deficiency, a congenital disorder characterized by an accumulation of 3-methylcrotonyl-glycine due to defective 3-methylcrotonyl-CoA carboxylase activity;

e. 3-Methylglutaconic aciduria, a congenital disorder characterized by elevated levels of 3-methylglutaconic acid due to defective 3-methylglutaconyl-CoA hydratase activity or a related enzyme;

f. Beta-ketothiolase deficiency, a congenital disorder characterized by an inability to metabolize 2-methyl-acetoacetyl-CoA due to defective mitochondrial acetoacetyl-CoA thiolase activity;

g. Glutaric acidemia type I, a congenital disorder characterized by an accumulation of glutaric acid due to defective glutaryl-CoA dehydrogenase activity;

h. Holocarboxylase synthase deficiency, a congenital disorder of multiple carboxylase deficiencies characterized by an inability to transport or metabolize biotin that leads to defective activity of propionyl-CoA carboxylase, beta-methylcrotonyl-CoA carboxylase, and pyruvate carboxylase;

i. Isobutyrylglycinuria, a congenital disorder characterized by an inability to metabolize the amino acid valine due to defective isobutyryl-CoA dehydrogenase activity;

j. Isovaleric acidemia, a congenital disorder characterized by an accumulation of isovaleric acid due to defective isovaleryl-CoA dehydrogenase activity;

k. Malonic acidemia, a congenital disorder characterized by an inability to metabolize fatty acids due to defective malonyl-CoA decarboxylase activity;

l. Methylmalonic acidemia (cobalamin disorders), a congenital disorder characterized by an accumulation of methylmalonic acid due to defective activity of methylmalonyl-CoA epimerase or adenosylcobalamin synthetase;

m. Methylmalonic acidemia (mutase deficiency), a congenital disorder characterized by an accumulation of methylmalonic acid due to defective methylmalonyl-CoA mutase activity;

n. Methylmalonic acidemia with homocystinuria, a congenital disorder characterized by the abnormal processing of cobalamin, leading to defective activity of methylmalonyl-CoA mutase and methionine synthase, for both of which cobalamin is a cofactor; and
o. Propionic acidemia, a congenital disorder characterized by an accumulation of glycine and 3-hydroxypropionic acid due to defective propionyl-CoA carboxylase activity; and

6. Other disorders, including:
   a. Biotinidase deficiency, a congenital disorder characterized by defective biotinidase activity that causes abnormal biotin metabolism and multiple carboxylase deficiencies;
   b. Classic galactosemia, a congenital disorder characterized by abnormal galactose metabolism due to defective galactose-1-phosphate uridylyltransferase activity;
   c. Cystic fibrosis, a congenital disorder caused by defective functioning of a transmembrane regulator protein and characterized by damage to and dysfunction of various organs, such as the lungs, pancreas, and reproductive organs;
   d. Galactosepimerase deficiency, a congenital disorder characterized by abnormal galactose metabolism due to defective UTP-galactose 4-epimerase activity;
   e. Galactokinase deficiency, a congenital disorder characterized by abnormal galactose metabolism due to defective galactokinase activity;
   f. Beginning May 1, 2023, glycogen storage disease type II or Pompe disease, a congenital disorder characterized by the accumulation of the polysaccharide, glycogen, in lysosomes due to a defect in the lysosomal acid alpha-glucosidase enzyme;
   g. Beginning May 1, 2023, mucopolysaccaridosis type I, a congenital disorder characterized by the buildup of the glycosaminoglycans, dermatan sulfate and heparan sulfate, due to defective alpha-L-iduronidase activity;
   h. Severe combined immunodeficiency, a congenital disorder usually characterized by a defect in both the T- and B-lymphocyte systems, which typically results in the onset of one or more serious infections within the first few months of life;
   i. Spinal muscular atrophy, a congenital disorder characterized by the loss of nerve cells in the spinal cord that control muscle movement due to a defect in the survival motor neuron 1 (SMN1) gene;
   j. T-cell related lymphocyte deficiency, a congenital disorder characterized by a defect in the T-lymphocyte system, which typically results in a decrease in cell-mediated immunity and unusually severe common viral infections; and
k. X-linked adrenoleukodystrophy, a congenital disorder characterized by the build-up of very long-chain fatty acids due to a deficiency in the adrenoleukodystrophy protein, caused by a defective \textit{ABCD1} gene.

B. When a bloodspot test is ordered for a newborn or an infant, a health care facility’s designee, a health care provider, or the health care provider’s designee shall:

1. Only use a specimen collection kit supplied by the Department;
2. Collect a blood sample from the newborn or infant on a specimen collection kit;
3. Complete the following information on the specimen collection kit:
   a. The newborn’s or infant’s name, gender, race, ethnicity, medical record number, and, if applicable, AHCCCS identification number;
   b. The newborn’s or infant’s type of food or food source;
   c. Whether the newborn or infant is from a single or multiple birth;
   d. If the newborn or infant is from a multiple birth, the birth order of the newborn or infant;
   e. Whether the newborn or infant has a medical condition that may affect the bloodspot test results;
   f. Whether the newborn or infant received a blood transfusion and, if applicable, the date of the last blood transfusion;
   g. The date and time of birth, and the newborn’s or infant’s weight at birth;
   h. The date and time of blood sample collection, and the newborn’s or infant’s weight when the blood sample is collected;
   i. The identification code or the name and address of the health care facility or health care provider submitting the specimen collection kit;
   j. The name, address, and telephone number or the identification code of the health care provider responsible for the management of medical services provided to the newborn or infant;
   k. Except as provided in subsection (B)(3)(l), the mother’s first and last names, date of birth, name before first marriage, mailing address, telephone number, and if applicable, AHCCCS identification number; and
   l. If the newborn’s or infant’s mother does not have physical custody of the newborn or infant, the first and last names, mailing address, and telephone number of the person who has physical custody of the newborn or infant; and
4. Submit the specimen collection kit to the Arizona State Laboratory no later than 24 hours or the next working day after the blood sample is collected.
C. A health care facility or a health care provider submitting a first initial specimen to the Arizona State Laboratory shall pay the Department the fee in R9-13-208(A) R9-13-208.

D. A person who submits a second specimen to the Arizona State Laboratory shall:
   1. Pay the fee in R9-13-208(B) to the Department, or
   2. Provide the following information to the Arizona State Laboratory for billing purposes:
      a. The name, mailing address, and telephone number of the newborn’s or infant’s parent or the individual responsible for paying, if not the parent; and
      b. If the individual responsible for paying has health care insurance for the newborn or infant, information about the health care insurance, including:
         i. The policyholder’s name;
         ii. The name and billing address of the health care insurance company;
         iii. The member identification number;
         iv. The group number, if applicable; and
         v. The effective date of the health care insurance; or
      c. That the individual responsible for paying has no health care insurance for the newborn or infant.

E. When a health care insurance company or an individual responsible for paying is identified as specified in subsection (D)(2), the health care insurance company or the individual responsible for paying shall pay the Department the fee in R9-13-208(B).

F. When a home birth not attended by a health care provider is reported to a local registrar, a deputy local registrar, or the state registrar under A.R.S. § 36-333:
   1. The local registrar, deputy local registrar, or state registrar shall notify the local health department of the county where the birth occurred; and
   2. The local health department’s designate shall:
      a. Collect a specimen from the newborn or infant on a specimen collection kit according to the requirements in R9-13-204(A)(2) or R9-13-205(C), and
      b. Submit the specimen collection kit to the Arizona State Laboratory no later than 24 hours or the next working day after the blood sample is collected.

G. A health care facility’s designate, a health care provider, or the health care provider’s designate shall ensure that:
   1. Educational materials are provided to the parent or guardian of a newborn or an infant for whom a bloodspot test is ordered, and
   2. The newborn’s or infant’s parent or guardian is informed of the requirement for a second specimen if the second specimen has not been collected.
For a home birth, a health care provider or the health care provider’s designee shall provide educational materials to the parent or guardian of a newborn or an infant for whom a bloodspot test is ordered.

R9-13-208. Fees Newborn Screening Program Fee

A. The fee for a first specimen is $36.00.

B. The fee for a second specimen is $65.00.

A. Until November 1, 2022, the fee for the newborn screening program is:

1. For a first specimen, $36; and
2. For a second specimen, $65.

B. Effective November 1, 2022, the fee for the newborn screening program is $171.00.
ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

July 2022
1. **An identification of the rulemaking**

   Arizona Revised Statutes (A.R.S.) § 36-694 contains requirements for ordering tests for certain congenital disorders and reporting congenital disorder test results and hearing test results to the Department, and establishes a newborn screening program, a central database for information about newborns and infants who are tested for congenital disorders or hearing loss, an educational program and follow-up services, and a newborn screening program committee. Current rules in Arizona Administrative Code (A.A.C.) Title 9, Chapter 13, Article 2, specify the congenital disorders being tested for, the information required when critical congenital heart defect screening is performed, the information required when a bloodspot specimen is collected from a newborn or infant, the person responsible for collecting the specimen, when the specimen should be collected, reporting requirements for a bloodspot test, reporting requirements for hearing tests, and fees. Laws 2021, Ch. 409, § 14, revised A.R.S. § 36-694 and directed the Department to adopt all of the NBS disorders included on the Recommended Uniform Screening Panel (RUSP) adopted by the Secretary of the U.S. Department of Health and Human Services, which, as of the effective date of the statutory change, included four additional core disorders and 26 secondary disorders (see Appendix A). A.R.S. § 36-694, as revised by Laws 2021, Ch. 409, § 14, also authorizes the program to establish a single program fee, by rule, to cover the expenses of operating the program. After obtaining an exception from the rulemaking moratorium established by Executive Order 2021-02, the Department is amending the rules in 9 A.A.C. 13, Article 2 to comply with Laws 2021, Ch. 409 in an iterative process.

   As required by Laws 2021, Ch 409, § 32, the Department has added, through expedited rulemaking, two of the core disorders, spinal muscular atrophy and x-linked adrenoleukodystrophy, to the congenital disorders being tested for, effective December 30, 2021. Now, the Department is further revising the rules to change from a specimen-based fee system to institute a single program fee, to be billed to the person submitting the initial specimen for a newborn or infant. The program fee will cover all the activities provided by the program. In addition, the Department is adding the remaining two core disorders, glycogen storage disease type II (Pompe disease) and mucopolysaccharidosis type I, as well as the 26 secondary disorders to the screening panel.

2. **Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rules**

   - The Department
- AHCCCS
- Third-party payors, including Indian Health Service, tribal health services, and insurance companies
- Health care institutions, including hospitals and birthing centers
- Health care providers, including physicians and midwives
- Parents of newborns
- General public

3. Cost/Benefit Analysis

This analysis covers costs and benefits associated with the rule changes to Laws 2021, Ch 409, expanding the NBS panel to include all RUSP conditions as part of a newborn and infant bloodspot test, establishing a single program fee paid by the person submitting the initial specimen, and making other clarifying changes. The calculations used throughout this analysis assume approximately 77,515 first specimens and 70,794 second specimens being received by the Department per fiscal year. Although the birth rate will vary, the projected costs and benefits should both vary in a similar fashion with the birth rate, since both screening tests should be offered to all newborns. Thus, the figures given should be comparable, regardless of their absolute size. Annual cost/revenue changes are designated as minimal when $2,700 or less, moderate when between $2,700 and $27,000, and substantial when $27,000 or greater in additional costs or revenues. A cost is listed as significant when meaningful or important, but not readily subject to quantification. A summary of the economic impact of the rules is given in the Table below, while the economic impact is explained more fully in the sections immediately following.

<table>
<thead>
<tr>
<th>Description of Affected Groups</th>
<th>Description of Effect</th>
<th>Increased Cost/ Decreased Revenue</th>
<th>Decreased Cost/ Increased Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. State and Local Government Agencies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department</td>
<td>Establishing a new program fee to replace a specimen-based fee Testing bloodspot specimens for all core RUSP disorders Providing follow-up on abnormal test results and collecting diagnoses on core and secondary disorders</td>
<td>Substantial</td>
<td>Substantial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substantial</td>
<td>Significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate-to-substantial</td>
<td>Significant</td>
</tr>
<tr>
<td>AHCCCS</td>
<td>Establishing a new program fee to replace a specimen-based fee Having babies with the added RUSP disorders diagnosed earlier, when the disorder may be better treated or cured</td>
<td>Substantial</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td>Substantial</td>
</tr>
</tbody>
</table>
### B. Privately Owned Businesses

<table>
<thead>
<tr>
<th>Category</th>
<th>Establishing a new program fee to replace a specimen-based fee</th>
<th>Minimal-to-substantial</th>
<th>Minimal-to-substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third-party payors, including Indian Health Service, tribal health services, and insurance companies</td>
<td>Establishing a new program fee to replace a specimen-based fee Having babies with the added RUSP disorders diagnosed earlier, when the disorder may be better treated or cured</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Health care institutions, including hospitals and birth centers</td>
<td>Establishing a new program fee to replace a specimen-based fee Having babies with the added RUSP disorders diagnosed earlier, when the disorder may be better treated or cured</td>
<td>Minimal-to-substantial</td>
<td>None</td>
</tr>
<tr>
<td>Health care providers, including midwives and physicians</td>
<td>Establishing a program fee to replace a specimen-based fee Having babies with the added RUSP disorders diagnosed earlier, when the disorder may be better treated or cured</td>
<td>Minimal-to-moderate</td>
<td>None</td>
</tr>
</tbody>
</table>

### C. Consumers

<table>
<thead>
<tr>
<th>Category</th>
<th>Establishing a program fee to replace a specimen-based fee</th>
<th>Minimal-to-substantial</th>
<th>Minimal-to-substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents of newborns or infants tested through NBS</td>
<td>Establishing a program fee to replace a specimen-based fee Having a baby screened for RUSP disorders Having a baby diagnosed earlier, based on screening results, when the disorder may be better treated or cured</td>
<td>None-to-minimal</td>
<td>None</td>
</tr>
<tr>
<td>General public</td>
<td>Having babies with added RUSP disorders diagnosed earlier, when the disorder may be better treated or cured</td>
<td>None</td>
<td>Significant/substantial</td>
</tr>
</tbody>
</table>

#### The Department

For many congenital disorders, early detection and treatment are critical in preventing death or a lifetime of disability due to the congenital disorder. Babies born with these disorders are at risk for a number of negative outcomes, including irreversible morbidity, developmental delays, or even death, if undiagnosed and untreated. With newborn screening, these disorders can be identified and treated early, improving outcomes. In addition, the medical costs and costs for other care for a baby or child with a disorder may be quite significant, but medical care for affected babies who are treated early is typically much less than for those who are diagnosed too late or not at all. The Newborn and Infant Screening Program (NBS) within the Department currently provides bloodspot testing for 29 congenital disorders, through the Arizona State Laboratory, and follow-up for newborns and infants who had an abnormal screening test result for one of the 29 congenital disorders, allowing these disorders to be identified early, as well as follow-up for a critical congenital heart defect, or hearing
Pursuant to A.R.S. § 36-694, as amended by Laws 2021, Ch. 409, § 14, the Department is adopting four additional core disorders and 26 secondary disorders included on the RUSP.

In addition to incurring costs for complying with A.R.S. § 36-694 related to bloodspot testing and follow-up, NBS also incurs expenses due to processing and notifying submitters about specimens for which results cannot be reported for any number of quality assurance reasons. These specimens are known as “Unsats” (being unsatisfactory for testing or reporting results) and are not billed for. Nor is NBS reimbursed for costs associated with “dietary monitoring,” testing a blood sample from an individual with a specific metabolic disorder that is treated through a restrictive diet for a specific analyte related to the disorder. As required by A.R.S. § 36-694, NBS also maintains and incurs costs for a central database of information about newborns and infants who are tested and provides an educational program for hospitals, health care providers, and parents. Under the specimen-based fee system, the Department cannot and does not charge a fee for these activities, despite incurring costs.

As part of NBS, the demographic data entry section enters information from a submitted specimen collection kit into a database system for linking with test results. Scientists in the Arizona State Laboratory review submitted specimens for acceptability, perform laboratory testing, maintain records of the tests performed, and conduct quality control studies of laboratory methods and practices. The follow-up section of NBS is responsible for promptly notifying physicians of abnormal bloodspot test results, linking physicians to appropriate specialty consultation services to ensure appropriate confirmatory testing, and verifying that infants with abnormal bloodspot test results and confirmatory results are under a physician’s care. The follow-up section also receives newborn and infant hearing test results and tracks infants who do not pass these tests in order to assist families with obtaining further confirmatory hearing testing and, when a hearing loss is confirmed, early intervention services. Results of newborn and infant critical congenital heart defect screening are collected and forwarded to the Department’s Birth Defects Monitoring Program. The education section of NBS provides educational outreach, educational materials, and training to the professional healthcare and lay communities about NBS and its requirements. Other components of the program include data management and billing. The data management component analyzes, evaluates, and reports program data, trends, and performance measures. Billing is addressed below. NBS also incurs expenses that represent expenditures that apply to the entire program (general program management), such as salaries for management and medical director, program database annual maintenance, specimen collection kits, statewide courier, utilities, and other computing infrastructure.

Under the current rules, the revenue for NBS is a specimen-based system. Those entities submitting a first specimen are billed and pay a fee of $36 per specimen. Those entities submitting a second specimen either pay the $65 fee for a second specimen or provide information that allows the Department to bill the fee to a third-party payor, such as healthcare insurance or the parent/responsible
individual. This specimen-based system requires the Department to essentially bill twice for each baby, since both first specimens and second specimens are collected from the vast majority of babies born each year.

Beginning in April 2016, the Department contracted with a private company, Midwest Medical Practice Management (MMPMI), to bill for NBS for both first specimens and second specimens. The contract with MMPMI ended in January 2021. As of November 2020, the billing contract was awarded to a new private company, American Exchange (A/E), which spent the first few months of the contract billing for specimens submitted during the transition from MMPMI. Because of the gap in billing and the fact that specimens submitted and specimen fees billed in one fiscal year may be collected in the next fiscal year, a more accurate indication of the revenue generated by billing for NBS specimens would be the average of the amounts billed and amounts collected during fiscal years 2019 through 2021. During fiscal years 2019 through 2021, the Department, by contract, billed an average of $7,235,598 per year for newborn and infant screening and collected an average of approximately $6,731,123 per year in specimen fees, as shown in Appendix B, for a total successful collection rate of approximately 93%. The revenue collected from the fees is deposited into the newborn screening program fund, established under A.R.S. § 36-694.01, from which the Legislature appropriates funds for the operation of NBS.

The percentage of collections versus billing differed between first specimens and second specimens. During FY2019 through 2021, the Department received an average of 77,515 first specimens for bloodspot testing, representing approximately 97% of births, and 70,794 second specimens, representing approximately 91% of first specimens. During those years, the Department billed an average of $3,512,046 to the health care facility or health care provider submitting the first specimen to the Department, according to R9-13-203(D), and collected an average of $3,521,660 from first specimen fees, which includes revenue received during FY 2019 from first specimens submitted and billed during FY 2018. The Department, thus, collected for essentially all first specimens billed. The Department also billed an average of $3,723,522 to third-party payors and parents for second specimens and collected an average of $3,209,462, a successful collection rate of only 86%.

During fiscal year 2021, the Department received an appropriation of $7,664,200 and $77,000 back-of-the-bill adjustment, for a total of $7,741,200, from the newborn screening fund to support NBS. This appropriation exceeded the average revenue generated by the fees. As shown in Appendix C, $368,916 was budgeted to support demographic data entry, $4,611,435 was budgeted to support the laboratory section, $619,061 was budgeted to support the follow-up section of NBS, $134,020 was budgeted to support the education section of NBS, $92,943 was budgeted to support data management, $784,491 was budgeted to support billing, $697,534 was budgeted to support general program
management activities, and $432,800 was budgeted for agency indirect and ITS direct costs. Thus, program costs were forecast to lead to total expenditures that would also exceed the expected revenue.

To ensure that the Department did not run out of funds to run the Program, the Department undertook cost-saving measures that still protected health and safety, but did not allow the Program to operate optimally. This resulted in expenditures that were less than the budgeted amounts for all components of the Program except Laboratory and Follow-up and included:

Demographics – A vacated position was not refilled, and a planned expansion in the use of optical character recognition to assist in demographic entry was postponed, resulting in a savings of $37,304.

Education – Vacancy savings and reduced travel resulted in a savings of $30,325.

Data management – Cancelled travel and reassigning personnel, with a concomitant change in allocation of salary, to another component of the Arizona State Laboratory resulted in a savings of $16,014.

Billing – A change in the billing contractor produced a reduction in the portion of the fee paid that was tied to collection, resulting in a savings of $333,741.

Program management – Reduced spending resulted in a savings of $43,962.

Indirect and ITS direct costs – Much of the amount assessed by the Department to cover operation of the Department was waived, resulting in a savings of $374,914.

While not totally covering the difference between revenue and the amount needed to adequately screen babies, to ensure their health and safety, these measures significantly reduced the shortfall and allowed the difference to be made up by other Department funds. However, they cannot be sustained without seriously jeopardizing health and safety.

As mentioned previously, Laws 2021, Ch. 409, required the Department to add two core disorders, spinal muscular atrophy and x-linked adrenoleukodystrophy, to the congenital disorders being tested for, effective December 30, 2021. In developing and vetting testing methodologies and beginning testing for these disorders, the Department incurred additional expenses that could not be covered by the existing fees. Through this rulemaking, the Department is further revising the rules add the remaining two core disorders, glycogen storage disease type II (Pompe disease) and mucopolysaccharidosis type I, as well as the 26 secondary disorders to the screening panel, as described in Appendix A. To cover the additional expenses related to adding these disorders to the NBS testing panel and the difference between historic revenues from the specimen-based fee system and usual Program expenses, the Department is instituting a single program fee of $171 to be paid by the submitter of an initial specimen submitted for a baby. This would equate to a real increase of $70 for a baby for whom both a first specimen ($36) and second specimen ($65) were submitted to the Department.
Although the Department plans to begin testing for the 26 secondary disorders when the new rules go into effect, the Department plans to delay implementation of this new fee until November 1, 2022 (based on the new rules going into effect in early September) to give AHCCCS and third-party payors time to update birth packages, according to A.R.S. § 36-694(I)(1) and (2), to reduce the burden of the new fee on hospitals. The Department plans to begin testing for the core disorders, glycogen storage disease type II (Pompe disease) and mucopolysaccharidosis type I, by May 1, 2023, well before the statutorily required date of December 31, 2023, established by Laws 2021, Ch 409, § 32. The Department needs the additional funds that will be generated by the new fee to procure, validate, and develop the expertise in performing the testing for the two new core disorders, to ensure the quality of the testing and accuracy of results. In addition, the manufacturer of the test also recommends that laboratories conduct a pilot study using a sufficient number of newborn samples (e.g. 10,000) with a target of identifying five or more samples from patients with known disease before beginning the general implementation of testing for the new core disorders.

The Department anticipates requiring approximately $5,590,000 in additional funds to adequately run the expanded program, for a total budget of approximately $13,331,200. In determining a fee that would produce this amount in revenue, the Department considered the number of initial specimens that were likely to be submitted. Initial specimens would include not only first specimens, as defined in R9-13-201, but also any second specimens, as defined in R9-13-201, for a baby who had not had a first specimen submitted. To estimate the number of initial specimens, the Department added the average number of first specimens (77,515) received during FY2019 through 2021 and the average number of unlinked second specimens (445), yielding an anticipated 77,960 initial specimens. By dividing $13,331,200 by 77,960, the Department derived the $171 fee.

Appendix C also shows the anticipated budget for the expanded Program and the expenses NBS will incur in implementing these changes. The increased funds are allocated as follows:

Demographics – The contract for the use of optical character recognition to assist in demographic entry will increase in cost, both due to inflation and for expansion to include second specimens. Costs associated with updated salaries, full use of performance incentives, and associated ERE increases for one supervisor and three support staff are also included. Because the Department has introduced an electronic reporting capability for first-screen submitters and those that sign up to retrieve their laboratory reports electronically instead of being mailed paper copies, the costs of mailing or faxing testing results and related supplies have decreased.

Laboratory – In order to provide adequate coverage for the expanded testing and maintain a reasonable supervisory span of control, the laboratory section will be reorganized from a single supervisor overseeing one team to the creation of three separate testing areas, each with its own supervisor and team lead. Staff will still be cross-trained and rotate within the different testing areas to
insure adequate coverage during planned or unplanned staff absences. This reorganization will require the addition of a supervisor, two additional team leads, and a laboratory technician to help organize and ensure the completion of daily side duties, for a total of four new FTEs. To reduce excessive staff turnover, updated salaries have been approved for laboratory staff. These updated salary levels are factored into the increase. The new staff will require new computers and software licenses, as well as desk and cell phones.

The largest portion of the increase for the laboratory section is due to the additional instrumentation, supplies, and reagents needed for the expanded testing panel. While screening for some added disorders will be accomplished by changing cut-off values for disorders in the current testing panels, others will require a reagent kit upgrade and all new instruments due to instrument aging problems, which will increase the reagent/rental price through which vendors are paid for instrumentation and reagent kits. Other tests will require a different instrument, setup, and reagents, as well as a separate service contract. Due to inflation, all vendors have indicated their intention to aggressively pursue the maximum annual cost increase allowed by contract. As a result, current vendor costs include a 3% annual increase over a five-year period. New studies were needed to verify the performance of the new reagent kits before they can be used for actual specimen testing, which requires the purchase of separate batches of reagents, supplies, and consumables that are not included in the reagent/rental price. Testing for Pompe disease and mucopolysaccharidosis type I requires a second-level of screening test for all specimens having an abnormal result on a first-level screening test to reduce the number of false positive results reported and the consequent increased cost of diagnostic testing and parental stress. Due to the difficulty in implementing the second-level test and anticipated high cost, the Department will send these specimens for testing to another laboratory under contract to do this testing.

Follow-up – An increase in the number of disorders being tested for is expected to result in a larger number of positive testing results that will require follow-up. In addition, existing staff shortages have resulted in a backlog in follow-up of positive testing results for the current screening panel of disorders. To alleviate these conditions, the follow-up section will expand from five to 11 FTEs, and three follow-up specialists (of the six new staff) have already been hired. In order to provide adequate coverage for the expanded testing and maintain a reasonable supervisory span of control, the follow-up section will be reorganized from a single supervisor overseeing the team to the creation of two follow-up areas, each with its own supervisor. One area will cover all the disorders in the current testing panel except hemoglobinopathies, the two newly added core disorders (spinal muscular atrophy and x-linked adrenoleukodystrophy), and the secondary disorders. The other will handle active follow-up of Pompe disease, mucopolysaccharidosis type I, and hemoglobinopathies, including hemoglobin traits. Staff will still be cross-trained in all disorders to insure adequate
coverage during planned or unplanned staff absences. Updated salary levels are again factored into the increase, as are new computers, software licenses, and desk and cell phones for the new staff. An overestimate of costs in the previous budget is accounted for as a reduction in costs.

To provide technical assistance to the Department and advise health care providers of babies with abnormal testing results, the Department contracts with specialists who can diagnose and treat the disorders that are part of the testing panel. Costs for current contracts (metabolic genetics) were updated to provide support for spinal muscular atrophy and many of the secondary disorders. Similarly, an increase in our existing hemoglobin subspecialist contract was included to cover the expected increase in program support for technical advice and assistance with follow-up of an increased number of presumptive positive hemoglobinopathy (and traits) patients. New contracts (pediatric neurology) were added to provide support for x-linked adrenoleukodystrophy, and a new subspecialist contract was included to cover the expected increase in program support for technical advice and assistance with follow-up for lysosomal storage disease (Pompe disease) presumptive positive patients.

Education – Although this budget increase includes an assumption of full use of performance incentives, along with the associated impact to ERE, the majority of the increase relates to the anticipated resumption of in-person outreach activities to health care providers, hospitals, and other professional groups, which includes the costs for travel (instate, out-of-state, and motor pool) and registration fees. A new contract will be initiated for a parent group to provide guidance and outreach material review, and a new software license will be purchased. An overestimate of costs in the previous budget is accounted for as a reduction in costs.

Data management – The majority of the increased costs will cover the recently filled data manager position and replace 90% of funding of an IT analyst who had previously been paid through grants, including an assumption of full use of performance incentives, along with the associated impact to ERE. Cancelled travel for one conference has been restored to the budget, along with the costs of new data analysis software. An overestimate of costs in the previous budget is accounted for as a reduction in costs.

Billing – With the adoption of a single program fee billed to submitters, the Department intends to discontinue the third-party billing contract after one year, leading to a substantial cost savings. Additional cost savings from the current budget are also realized due to the reduction in the percentage charged by the billing company that is tied to collection from 8% to 3.5%. These savings will be partially offset by increased costs to perform the billing function in-house. In-house billing adds one FTE, along with associated ERE and phone costs, and one temporary employee. Costs for existing staff include updated salaries and the full use of performance incentives along with the associated impact to ERE. The cost of a simple billing program is also included.
Program management – Several vendors are covered under this section of the Program. As mentioned above, all vendors have indicated their intention to pursue the maximum annual cost increase allowed by contract, which will result in a 3% annual increase in current vendor costs over a five-year period. This is also true for Natus, the program data management software that constitutes the central database required by A.R.S. § 36-694(E).

As mentioned above, the Program currently does not charge for “Unsats” (specimens that are unsatisfactory for testing or reporting results) or for “dietary monitoring” samples because they do not fit under the specimen-based fee system. However, the Program does incur costs associated with these specimens and is accounting for the costs of reagents and supplies to cover approximately 665 such specimens that had previously generated unrecoverable costs. The budget increase also includes updated salaries and an assumption of full use of performance incentives for existing staff, along with the associated impact to ERE. Funds for registration and travel for one conference is also included.

Indirect and ITS direct costs – The budget includes the full amount assessed by the Department to cover operation of the Department, with the increase reflecting changes in indirect that take staff changes into account.

As mentioned above, the Department collected essentially all funds billed to submitters of first specimen, but was only successful in collecting 86% of what was billed for second specimens. Therefore, the Department anticipates that the use of in-house invoicing of a single program fee to submitters of initial specimens will likely completely eliminate the hundreds of thousands of dollars annually written off as uncollectible from those billed for second specimens, resulting in a substantial benefit. In addition, with no additional fee associated with the submission of a second specimen, more babies may receive a second newborn screening test, providing a significant benefit to the Department in protecting health and safety. These effects are on top of the major significant benefit of adding the disorders described in Appendix A to the newborn and infant screening panel in promoting public health and protecting the health of babies born with one of the added disorders.

- **AHCCCS**

  According to CY 2019 birth data from the Department's Health Status and Vital Statistics group, there were 79,183 births recorded, of which 38,691 were paid through AHCCCS. Thus, AHCCCS was the party paying for delivery for 48.9% of all births [38,691/79,183]. The Department expects that the first specimens for all babies born in a hospital or birthing center will be submitted by the health care facility where the birth occurred. Therefore, the Department would anticipate that funds provided by AHCCCS, through negotiated “birth packages” with Arizona’s hospitals and birthing centers, would be used to pay the fee in R9-13-208 for approximately 48.9% of initial specimens. According to A.R.S. § 36-694(I)(2), AHCCCS is required to update the rates included in birth packages to reflect the fee increase. Although AHCCCS may incur costs related to actually updating these birth packages
(beyond the costs for claims against the birth packages), those costs are imposed by the statutory change rather than the rules and are not addressed here. However, as stated above, the Department plans to delay implementation of the new fee until November 1, 2022, to give AHCCCS time to comply with A.R.S. § 36-694(I)(2).

Since a second specimen for most babies would be collected and submitted after the baby leaves the hospital or birthing center, the increase in birth packages would likely only need to cover the $135 difference between the current rate for first specimens ($36) and the rate for an initial specimen ($171), without addressing the current cost for a second specimen. Assuming that AHCCCS would be the payor for approximately the same percentage of babies in future years, the Department anticipates that the rule changes would impose on AHCCCS approximately the following increase in costs related to birth packages:

Average of 77,515 first specimens X 48.9% = 37,905 first specimens with AHCCCS as the payor
37,905 X $135 = $5,117,175 increase from renegotiated birth packages

This increase would be partially offset by the elimination of the fee for a second specimen for which there is a linked first specimen. Assuming that the same percentage of second specimens would be submitted for babies covered under AHCCCS, the Department anticipates that this change in the fee structure would provide the following decrease in costs to AHCCCS:

Average of 70,794 second specimens X 48.9% = 34,618 second specimens
34,618 X $65 = $2,250,170 decrease in costs for second specimen fees

A baby covered under AHCCCS is likely to have both first and second specimens submitted for testing because both specimens would be covered. Thus, it is less likely that a baby covered under AHCCCS would have an unlinked second specimen, which would be considered an initial specimen and for which the $171 program fee would be charged, rather than the $65 fee for a second specimen under the current rules ($106 difference). However, if the same percentage of unlinked second specimens were from babies covered under AHCCCS, AHCCCS could incur the following additional costs:

Average of 445 X 48.9% = 218 unlinked second specimens
218 unlinked second specimens X $106 = $23,108

Thus, the Department estimates that AHCCCS may bear as much as an additional $2,890,113 in costs from the rule changes ($5,117,175 + $23,108 - $2,250,170).

The Department anticipates that AHCCCS may also receive a substantial benefit from the addition of the many new congenital disorders that are part of the revised screening panel. As mentioned above, babies born with these new disorders are at risk for a number of negative outcomes (See Appendix A). With newborn screening, these disorders can be identified and treated early, improving outcomes. A positive screening result also allows targeted diagnostic testing for a disorder, eliminating the
“diagnostic odyssey” and, thus, reducing the number of tests before a diagnosis is made and the costs of these tests. The costs to treat the disorder are also generally less with an early diagnosis.

- **Third-party payors**

  Third-party payors include private insurance plans, military health care facilities, Indian Health Service, and tribal health care facilities. Of the 79,183 recorded births in CY 2019, as many as 36,702 births (those births that were not listed as AHCCCS or self-pay) were paid for by third-party payors, for approximately 46.4% of all births [36,702/79,183], based on data from the Department's Health Status and Vital Statistics group. As with AHCCCS, third-party payors pay for births through negotiated birth packages with hospitals and birthing centers. According to A.R.S. § 36-694(I)(1), many third-party payors are required to update the rates included in birth packages to reflect the fee increase. Although they may incur costs related to updating these birth packages, those costs are also imposed by the statutory change rather than the rules and are not addressed here. However, the delayed implementation of the new fee until November 1, 2022, will give third-party payors time to comply with A.R.S. § 36-694(I)(1).

  Again, most babies would have a first specimen collected by the facility at which the birth occurred, but a second specimen would be collected and submitted after the baby leaves the hospital or birthing center. Therefore, the increase in birth packages would need to cover the $135 difference between the current rate for first specimens and the rate for an initial specimen. Assuming approximately the same percentage of babies in future years, the Department anticipates that the rule changes would impose on third-party payors in total approximately the following increase in costs related to birth packages:

  Average of 77,515 first specimens X 46.4% = 35,967 first specimens with a third-party payor
  
  35,967 X $135 = $4,855,545 increase from renegotiated birth packages

  The actual cost increase related to the difference in fees would vary from one payor to another, depending on the number of babies covered under the third-party payor, and would likely range from minimal to substantial.

  Although the Department only bills third-party payors the fee for a second specimen under the current rules, the Department estimates that, for the vast majority of babies, those third-party payors who paid the fee for a second specimen would most likely also have paid for the birth. Thus, the Department reviewed data for payment of second specimens to estimate the financial burden of the new program fee on individual third-party payors who would be updating the amount paid for birth packages according to A.R.S. § 36-694(I)(1). Based on these data, the Department anticipates that approximately 15 of the over 100 third-party payors billed for second specimens would incur substantially increased costs, with approximately 10 paying over $200,000 more per year for birth
packages. The Department believes that approximately 20 could incur a moderate increase in costs, and the remaining third-party payors would incur a minimal increase.

This increase would be partially offset by the elimination of the fee for a second specimen for which there is a linked first specimen. Not having the Department submit a separate bill for a second specimen for each covered baby may also provide as much as a substantial administrative cost savings for third-party payors, who would not have to process these bills and submit payments to the Department. Assuming that the same percentage of second specimens would be submitted for babies covered under a third-party payor, the Department anticipates that the change in the fee structure would provide the following decrease in costs to third-party payors in general, in addition to the savings derived from not having to process a separate bill:

Average of 70,794 second specimens X 46.4% = 32,848 second specimens

32,848 X $65 = $2,135,120 decrease in costs for second specimen fees

Actual savings to a single third-party payor would also vary with the number of second specimens for babies covered by the third-party payor, but the Department anticipates this would range from minimal to substantial, with approximately 14 individual third-party payors receiving a substantial benefit, approximately 10 receiving a moderate benefit, and the remainder receiving a minimal benefit.

As for AHCCCS, an unlinked second specimen would also be billed as an initial specimen, with a $171 program fee rather than the $65 fee for a second specimen under the current rules, resulting in a $106 difference in costs. If the same percentage of unlinked second specimens were from babies covered by third-party payors, they, in total, could incur the following additional costs:

Average of 445 X 46.4% = 206 unlinked second specimens

206 unlinked second specimens X $106 = $21,836

Thus, third-party payors in total may bear an additional $2,742,263 from the rule changes ($4,855,545 + $21,838 - $2,135,120) with the actual increased cost for a single third-party-payor likely ranging from minimal to substantial. Third-party payors may pass the costs of the increased fee on to policy holders as increased insurance premiums or otherwise recoup these costs. The Department estimates that the additional costs to third-party payors from the change in fee structure may essentially be offset from these funding sources.

The disorders added to the newborn screening panel can be identified and treated early, improving outcomes. As for AHCCCS, the Department anticipates that a third-party payor may receive up to a substantial cost savings from the addition of the many new congenital disorders that are part of the revised screening panel if affected babies, insured through the third-party payor, are identified through NBS, allowing targeted diagnostic testing for a disorder, instead of the “diagnostic odyssey.” The Department believes this will reduce the number of tests before a diagnosis is made and the costs of
these tests and allow for treatment of the disorder at a time when the cost of the treatment are generally less.

**Health care institutions**

Most first specimens are collected from a newborn before the newborn is 72 hours old and thus, would be collected by the facility at which the birth occurred, as stated above. These facilities are for the most part hospitals or birth centers licensed under A.R.S. Title 36, Chapter 4, Article 2, and 9 A.A.C. 10 as health care institutions or similar tribal or federal facilities. During 2021, approximately 11 facilities submitted more than 1,000 first specimens each, while another 17 submitted between 200 and 1,000 first specimens. Approximately 15 hospitals and 3 birth centers submitted between 20 and 200 first specimens. The remainder of these facilities submitted fewer than 200 first specimens each. Currently, the Department bills these facilities the $36 fee for submitted first specimens, and the Department expects to bill them for the vast majority of initial specimens. Therefore, the health care institutions providing maternity services could be expected to incur an increase of $135 (the difference between the current rate for first specimens and the rate for an initial specimen) in costs due to the fee increase for each initial specimen submitted. If similar numbers of initial specimens are submitted in the future, approximately 28 facilities would be expected to incur a substantial increase in costs due to the change in the fee, while approximately another 18 facilities would be expected to incur a moderate increase in costs due to the change in the fee, with the rest incurring a minimal increase in costs. This increase in cost should be offset by the increase in the rate for birth packages required in A.R.S. § 36-694(I) for any birth covered by AHCCCS or a third-party payor. The Department anticipates that the delayed implementation of the new fee until November 1, 2022, allowing birth packages to be updated before its implementation, may provide up to a substantial benefit to these facilities. For those births not subject to the requirements in A.R.S. § 36-694(I), the Department anticipates that the health care institution will incur an additional cost of $135 for each initial specimen from a baby whose birth was not covered by AHCCCS or a third-party payor.

A hospital, outpatient treatment center, or other health care institution that is authorized to provide services required to diagnose a baby with a positive screening test or treat a baby with a diagnosis of one of the added disorders may also be affected by the addition of new disorders to the newborn screening panel of conditions as part of the rulemaking. An affected baby, identified through NBS and either treated or cured of the condition, could avoid morbidities that would otherwise have sent the baby to the health care institution for treatment, decreasing the revenue to these health care institutions. The Department anticipates that a health care institution may incur a moderate-to-substantial decrease in revenue if an affected baby is identified through NBS and avoids multiple diagnostic tests/procedures to determine a diagnosis, extensive treatment to address the effects of disease progression, or more expensive treatment once the disorder has become symptomatic.
However, a health care institution may also receive a moderate-to-substantial increase in revenue from providing on-going, but likely less expensive, treatment to an affected baby/child, who might otherwise have died, as well as receive a significant benefit in knowing that a baby, who was identified through NBS and who has been treated and/or cured, is healthy.

- **Health care providers (midwives, pediatricians, and primary care providers)**

  Midwives as a whole submit fewer than 300 first specimens per year for the newborns they deliver from their clients and are the only health care providers who have submitted first specimens, according to Department records. If a similar number of initial specimens is submitted by midwives in upcoming years, the Department would expect midwives as a whole to incur less than $40,500 in increased costs due to the new fee for newborns delivered by a midwife. The number of first specimens submitted by individual midwives in FY2020 ranged from one to 32, with only three submitting 20 or more first specimens. Therefore, an individual midwife is expected to incur at most a moderate increase in costs (32 X $135 = $4,320), and all but the largest submitters incurring a minimal increase in costs. A midwife may also pass the costs of the increased fee for an initial specimen on to clients as increased midwifery fees.

  It is likely that some babies will not have a first specimen collected from them. For these babies, a second specimen, collected through the baby’s pediatrician or primary care provider, will be unlinked to a first specimen and considered an initial specimen. The Department expects to bill the submitters of these initial specimens the $171 program fee. From the small number of these specimens that the Department receives annually (average of 445 unlinked second specimens over the past three years), the Department anticipates that a health care provider submitting one or more unlinked second specimens would incur at most a minimal increase in costs.

  The Department believes that all health care providers may also receive a significant benefit in knowing that an affected baby, identified through NBS, is treated or cured and is healthy.

- **Parents of newborns**

  Parents paid for about 4.8% of births (percentage of self-paid births – 3,790/79,183) in Arizona in CY2019, according to data from the Department's Health Status and Vital Statistics group. A parent paying a health care facility or health care provider for the delivery of the newborn would likely have the fee for newborn and infant screening included in the fee charged by the health care facility or health care provider for the delivery. A parent may also incur an increase in the premium paid to a third-party payor that passes the increased newborn screening program fee on to policyholders. The Department expects that the increased cost to an individual parent to be at most minimal, either directly from the fee change or indirectly through an increase in a health insurance premium or midwifery fee.
The tests used for newborn and infant screening have a high sensitivity, and the cut-off values for a positive test result are set to ensure that, while there may be false positive results, a false negative result (a negative test result from a baby that really has the condition tested for) is very rare. Because a false positive result may occur, a parent of a newborn with a positive screening test result may experience stress due to the uncertainty about the health of the parent’s newborn and will need to obtain diagnostic testing to determine if the screening test result means newborn is affected with the target disorder or another disorder, or whether it is a false positive result. However, the parent of a baby affected with an added disorder or another condition may receive a significant and perhaps up to a substantial benefit from having the condition diagnosed early, through targeted testing, rather than undergo months of stress, have the baby undergo a multitude of tests to try to obtain a diagnosis, and experience the monetary and emotional toll of having a sick child.

- **General public**
  
  As mentioned above, affected babies who are not identified through NBS, and left undiagnosed and untreated, may experience a range of adverse outcomes including irreversible morbidity, developmental delays, and, for some disorders, death. Society in general will receive a significant benefit from having a baby grow up into a healthy and productive member of society because of timely identification and treatment. In addition, the general public is expected to receive up to a substantial benefit from the addition of these disorders to newborn and infant screening by having fewer affected individuals identified later when costs of treatment are higher.

4. **A general description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking**

Public and private employment in the State of Arizona are not expected to be affected due to the changes in the rules.

5. **A statement of the probable impact of the rules on small business**

   a. **Identification of the small businesses subject to the rules**

   Small businesses subject to the rule may include small hospitals, small outpatient treatment centers or birth centers, small insurance carriers, physician practices, and midwives.

   b. **The administrative and other costs required for compliance with the rules**

   The fee increase may impose an increased cost to a small hospital or birth center that does not receive an increase in the fee for a birthing package from AHCCCS or a third-party payor and does not pass the increased cost for newborn screening on to a parent. The fee change may impose an increased cost to a midwifery practice that does not pass the increased cost on to a parent. The fee increase may impose an increased cost on a small insurance carrier or other third-party payor that covers newborn and infant screening for a newborn or infant, which may be offset by higher premiums or lower medical costs for affected babies diagnosed through
NBS, rather than once symptoms arise and additional medical treatment is required. Additional information is provided under paragraph 3.

c. **A description of the methods that the agency may use to reduce the impact on small businesses**

The Department is planning a delayed implementation date of November 1, 2022, for the new program fee to enable AHCCCS and third-party payors time to comply with A.R.S. § 36-694(I)(1) and (2), thus, reducing the financial burden on facilities submitting initial specimens until birth packages can be updated. In addition, the Department provides outpatient treatment centers, midwives, and other free-standing small healthcare-related facilities with free, in-person training upon request. These small businesses, as well as other health care institutions and health care providers, also have access to free parent and provider brochures and other materials in English and Spanish and can request assistance with establishing their facility as a screening location for newborns/infants. Training includes a “getting started” packet covering collection technique, timing, drying, and shipping for specimens, as well as information for families related to disorders tested for through NBS. The Department also contracts with physicians specializing in disorders in the screening panel, who can serve as a resource to health care providers, as well as the Department. Additionally, resources are provided related to hearing screening, insurance reimbursement, and other administrative tasks associated with appropriate screening and education to families. Family support resources are also offered, and a review of the website is provided to ensure stakeholders know how to access information as needed. Except as described above, the Department is unaware of another method that may be used to reduce the impact on small businesses.

d. **The probable costs and benefits to private persons and consumers who are directly affected by the rules**

If the parents of a newborn or infant have no health care insurance for the newborn or infant, the parents may bear the cost of the program fee for the newborn and infant screening program. However, for most parents (those whose babies have negative test result), the parents will benefit from the knowledge that the parent’s newborn does not have a screened disorder. For those parents receiving a positive screening result, the parent can benefit from targeted testing for a screened disorder. If the newborn is diagnosed with a disorder after a positive newborn and infant screening test, those parents can benefit from early diagnosis and treatment/cure to avoid a stressful diagnostic odyssey and costly medical and other expenses, including the death of the baby in some cases. Additional information is provided under paragraph 3.

6. **A statement of the probable effect on state revenues**
The funds generated through newborn screening fees are placed into a newborn screening fund, from which the Legislature appropriates funds to run NBS within the Department. The Department anticipates that approximately $5,590,000 in additional funds will be generated to run the expanded program, as described in paragraph 3.

7. **A description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking**

There are no less intrusive or less costly alternatives for achieving the purpose of the rule.

8. **A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data**

The financial data used to develop this document was obtained, as cited, from the Department’s newborn screening database, vital statistics data, and financial records and projections, not from any outside data. Information about the costs related to added disorders was obtained from published research and review articles in scientific and medical journals. As such, the Department believes the data is acceptable.
## Appendix B

### Billing and Revenue Data

Three-Year Averages for Specimens, Billing, and Revenue

<table>
<thead>
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<th>FY</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>Average</th>
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<tbody>
<tr>
<td><strong>Number of:</strong></td>
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<td></td>
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<tr>
<td>First specimens</td>
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<td>Anticipated Budget</td>
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<td>$4,752,860</td>
<td>-$141,425</td>
<td>$8,903,717</td>
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<tr>
<td>Follow-up</td>
<td>$619,061</td>
<td>$626,993</td>
<td>-$7,932</td>
<td>$1,241,995</td>
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<tr>
<td>Education</td>
<td>$130,020</td>
<td>$103,695</td>
<td>$30,325</td>
<td>$164,410</td>
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<tr>
<td>Data Mgmt</td>
<td>$92,043</td>
<td>$76,320</td>
<td>$16,014</td>
<td>$248,845</td>
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<tr>
<td>Billing</td>
<td>$784,491</td>
<td>$650,749</td>
<td>$333,741</td>
<td>$262,258</td>
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<tr>
<td>Program Mgmt</td>
<td>$597,534</td>
<td>$803,573</td>
<td>$407,039</td>
<td>$848,834</td>
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<tr>
<td>Indirect/ITS Direct</td>
<td>$432,800</td>
<td>$377,886</td>
<td>$54,914</td>
<td>$1,068,719</td>
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<tr>
<td>Total</td>
<td>$7,741,200</td>
<td>$7,054,298</td>
<td>$686,902</td>
<td>$13,331,119</td>
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<tr>
<td>Appropriated Amount</td>
<td>$7,664,200</td>
<td>$13,576,900</td>
<td></td>
<td></td>
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<tr>
<td>Adjustment</td>
<td>$77,800</td>
<td></td>
<td></td>
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<tr>
<td>Total Appropriation</td>
<td>$7,741,200</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
### Appendix A

**Expansion Disorders**

<table>
<thead>
<tr>
<th>Core Disorders</th>
<th>Incidence</th>
<th>Expected Cases/Year</th>
<th>States Testing*</th>
<th>Disorder Description</th>
<th>Treatment Description/Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ALD X-linked adrenoleukodystrophy</td>
<td>1:15,000</td>
<td>4-5</td>
<td>22</td>
<td>X-linked adrenoleukodystrophy (ALD) is a genetic disorder that mainly affects the nervous system and the adrenal glands, which are small glands located on top of each kidney. In this disorder, the fatty covering (myelin) that insulates nerves in the brain and spinal cord tends to deteriorate (a condition called demyelination). The loss of myelin reduces the ability of the nerves to relay information to the brain. In addition, damage to the outer layer of the adrenal glands (adrenal cortex) causes a shortage of certain hormones (adrenocortical insufficiency). Adrenocortical insufficiency may cause weakness, weight loss, skin changes, vomiting, and coma. Children with childhood cerebral ALD will have ongoing neurological deterioration. Unless hematopoietic cell transplantation (stem cell bone marrow transplantation) is done early, the child will continue to lose neurologic abilities. Sadly, without HCT, most children with ALD will die before age ten.</td>
<td>Allogeneic hematopoietic cell transplantation (HCT) or stem cell transplantation. HCT is a treatment that may halt the progression of ALD in children if the disease is diagnosed and treated early. Stem cells are taken from umbilical cord blood or bone marrow from a healthy, matched donor and given to the child with ALD. Individuals who have adrenal insufficiency need to have regular adrenal gland testing, and can be treated effectively with replacement corticosteroids. The medication replaces what the body would have made daily, but needs to be carefully monitored and adjusted as individuals grow. Illnesses and other stressors such as surgery require increased doses. Without NBS: - mortality of 0.7089 - total treatment costs are approximately $917,000 [With NBS:] - mortality rate of 0.1273 - total treatment costs are approximately $977,000</td>
</tr>
<tr>
<td>SMA Spinal muscular atrophy</td>
<td>1:8,000-10,000</td>
<td>7-8</td>
<td>37</td>
<td>Spinal muscular atrophy is a genetic disorder characterized by weakness and wasting (atrophy) in muscles used for movement (skeletal muscles). It is caused by a loss of specialized nerve cells, called motor neurons, that control muscle movement. With NBS, babies can receive treatment before loss of motor neurons occurs.</td>
<td>There are 3 FDA approved treatments for SMA. Treatment is needed prior to the onset of symptoms to prevent further neuronal damage. - Zolgensma is a one-time treatment that works by replacing the function of the missing SMN1 gene with a new, working copy of the gene. It requires a one-time fee of $2.1 million for gene therapy. - Spinraza is an intrathecal injection requiring four “loading doses” and then doses every four months for life. - Evrysdi is an oral medication designed to increase SMN protein levels in the CNS that is taken daily for life.</td>
</tr>
<tr>
<td>MPS-I Mucopolysaccharidosis type I</td>
<td>1:100,000</td>
<td>&lt;1</td>
<td>26</td>
<td>Mucopolysaccharidosis type I (MPS I) is a lysosomal storage condition that affects many parts of the body. This disorder was once divided into three separate syndromes: Hurler syndrome (MPS I-H), Hurler-Scheie syndrome (MPS 1-H/S), and Scheie syndrome (MPS 1-S), listed from most to least severe. Because there is so much overlap between each of these three syndromes, MPS I is currently divided into the severe and attenuated types.</td>
<td>Treatment for MPS I varies. Treatment can include physical therapy, dietary changes, surgeries, medications, enzyme replacement therapies (ERT), and stem cell transplantation. ERT cost is approximately $218,00.</td>
</tr>
</tbody>
</table>
### Pompe Glycogen storage disease type II (Pompe disease)

Pompe disease is an inherited lysosomal storage disorder caused by the buildup of a complex sugar called glycogen in the body's cells. The accumulation of glycogen in certain organs and tissues, especially muscles, impairs their ability to function normally. Eight publications evaluated patients with infantile-onset Pompe disease (IOPD) (two studies), late-onset Pompe disease (LOPD) (four studies), or both (two studies). Treatment for Pompe can include enzyme replacement therapy, physical therapy, respiratory therapy, and dietary treatments.

In IOPD, total cost of supportive therapy (excluding treatment) was $41,667. Health economic evaluations estimating incremental costs per quality-adjusted life year (QALY) gained with enzyme-replacement therapy (ERT) versus supportive therapy ranged from $186,851 per QALY to $1,323,207.

<table>
<thead>
<tr>
<th>Secondary Disorders</th>
<th>Incidence</th>
<th>Expected Cases/Year</th>
<th>States Testing*</th>
<th>Disorder Description</th>
<th>Treatment Description/Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2M3HBA 2-Methyl-3-hydroxybutyric aciduria or HSD10 disease</td>
<td>1:1,000,000</td>
<td>0</td>
<td>26</td>
<td>HSD10 disease is a disorder that affects the nervous system, vision, and heart. It is typically more severe in males than in females. Most affected males have a form of HSD10 disease in which early development seems normal, followed by a stage in which affected individuals rapidly lose skills they have acquired. This developmental regression often occurs between the ages of 1 and 2 and results in severe intellectual disability and loss of communication skills and motor skills such as sitting, standing, and walking.</td>
<td>Treatment includes implementing a carefully planned diet to avoid proteins that the baby cannot break down. Baby should avoid fasting and will require close observation during illnesses as well.</td>
</tr>
<tr>
<td>2MBG 2-Methylbutyryl glycinuria</td>
<td>unknown, relatively common among Hmong population</td>
<td>0</td>
<td>28</td>
<td>There have been very few reported cases of 2-methylbutyryl glycinuria (2MBG). Of those reported, all of the babies were healthy at birth. Signs of 2MBG often begin in infancy, sometimes as early as a few days after birth. In other cases, signs do not develop until childhood. If treated early, a baby can have healthy growth and development.</td>
<td>Prevention of the symptoms of 2MBG is done with a very restricted diet. A dietician or a nutritionist can help plan a low-protein diet that still gives the nutrients needed for healthy growth. The use of special baby formulas and foods designed for children with 2MBG is sometimes needed. These formulas will likely need to be continued through adulthood. Eating often can prevent many of the signs and symptoms. Infections can also trigger problems. Doctors may prescribe L-carnitine supplements as well.</td>
</tr>
<tr>
<td>3MGA 3-Methylglutaconyl-CoA hydratase deficiency (3-Methylglutaconic aciduria)</td>
<td>Rare- Only 20 known cases</td>
<td>0</td>
<td>33</td>
<td>3-methylglutaconyl-CoA hydratase deficiency is an inherited condition that causes neurological problems. Beginning in infancy to early childhood, children with this condition often have delayed development of mental and motor skills (psychomotor delay), speech delay, involuntary muscle cramping (dystonia), and spasms and weakness of the arms and legs (spastic quadriaparesis). Affected individuals can also have optic atrophy, which is the breakdown (atrophy) of nerve cells that carry visual information from the eyes to the brain.</td>
<td>Treatment includes close cardiac monitoring by a cardiologist. There are no specific treatments available. Infections should be treated immediately in babies with 3MGA.</td>
</tr>
<tr>
<td>IBD Isobutyryl-CoA dehydrogenase deficiency (Isobutyrylglycinuria)</td>
<td>Rare - fewer than 30 known cases</td>
<td>0</td>
<td>26</td>
<td>Isobutyryl-CoA dehydrogenase (IBD) deficiency is a condition that disrupts the breakdown of certain proteins. Normally, proteins from food are broken down into parts called amino acids. Amino acids can be further processed to provide energy for growth and</td>
<td>Treatment includes a restricted diet that avoids proteins. Special formulas and foods may be used as well. Dietary treatment is lifelong.</td>
</tr>
<tr>
<td>Disorder</td>
<td>Prevalence</td>
<td>Age of Onset</td>
<td>Description</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>----------</td>
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<td></td>
</tr>
<tr>
<td><strong>MAL</strong> Malonyl-CoA decarboxylase deficiency (Malonic acidemia)</td>
<td>Rare - fewer than 30 known cases</td>
<td>0 - 35</td>
<td>Malonyl-CoA decarboxylase (Malonic Acidemia) deficiency is a condition that prevents the body from converting certain fats to energy. The signs and symptoms of this disorder typically appear in early childhood. Almost all affected children have delayed development. Additional signs and symptoms can include weak muscle tone (hypotonia), seizures, diarrhea, vomiting, and low blood sugar (hypoglycemia). A heart condition called cardiomyopathy, which weakens and enlarges the heart muscle, is another common feature of malonyl-CoA decarboxylase deficiency. Treatment includes a diet which avoids high fat foods. L-Carnitine supplementation to help break down fats may also be prescribed. Costs associated with seeing a metabolic geneticist - L-carnitine supplementation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cbl C,D</strong> Methylmalonic acidemia and Methylmalonic acidemia with homocystinuria</td>
<td>1:200,000</td>
<td>0 - 39</td>
<td>Methylmalonic acidemia is an inherited condition in which the body is unable to process certain fats and proteins. It is considered an organic acid condition because it can lead to a harmful excess of certain toxins and organic acids. Methylmalonic acidemia with homocystinuria (Cbl C, D, F) is one type of methylmalonic acidemia. Individuals with this form of methylmalonic acidemia have trouble producing certain cobalamin enzymes, which causes harmful levels of homocysteine and methylmalonic acid to build up in their bodies. There are other forms of methylmalonic acidemia that occur without homocystinuria. The baby will probably need to be on a restricted diet to avoid proteins that their body cannot break down. A dietitian or nutritionist can help plan a low-protein diet that still gives the baby the right nutrients for healthy growth. Special formulas or foods especially for children with methylmalonic acidemia with homocystinuria (Cbl, C, D, F) will be prescribed. These formulas will likely need to continue through adulthood. Eating often will also help prevent symptoms. Illnesses and infections can also trigger symptoms. Costs associated with seeing a metabolic geneticist and special formulas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DE RED</strong> 2,4 Dienoyl-CoA reductase deficiency</td>
<td>Only 1 reported case</td>
<td>0 - 22</td>
<td>2,4 Dienoyl-CoA reductase deficiency (DE RED) has only ever been reported once. From birth, this baby had signs including: small body and head size; short torso, arms, and fingers; weak muscle tone (known as hypotonia); poor appetite; vomiting; irritability; and delayed weight gain. In the single case of 2,4 Dienoyl-CoA reductase deficiency (DE RED), the baby was treated with a low-lysine formula. Lysine is an amino acid, a building block made of proteins. The baby who had this disorder had dangerously high levels of this substance in the blood.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CACT</strong> Carnitine-acylcarnitine translocase deficiency</td>
<td>Very rare - Only 30 cases ever reported</td>
<td>0 - 42</td>
<td>Carnitine-acylcarnitine translocase (CACT) deficiency is a condition that prevents the body from using certain fats for energy, particularly during periods without food. Signs and symptoms of this disorder usually begin soon after birth and may include breathing problems, seizures, and an irregular heartbeat. Affected individuals typically have low blood sugar and a low level of ketones, which are produced during the breakdown of fats and used for energy. People with CACT deficiency also usually have excess ammonia in the blood, an enlarged liver, and a weakened heart muscle. Many infants with CACT deficiency do not survive the newborn period. Some affected individuals have a less severe form of the condition and do not develop signs and symptoms until CACT is treated with dietary restrictions to avoid foods that their body cannot break down. Children often take MCT oil (medium chain triglycerides). This oil contains fats that they can break down for energy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| CPT IA  
Carnitine palmitoyltransferase I | Rare - < 50 known cases (more common in Hutterite and Inuit population) | 0 | 30 | Carnitine palmitoyltransferase I (CPT I) deficiency is a condition that prevents the body from using certain fats for energy, particularly during periods without food. The severity of this condition varies among affected individuals. Signs and symptoms of CPT I deficiency often appear during early childhood. Affected individuals usually have low blood sugar and a low level of ketones, which are produced during the breakdown of fats and used for energy. People with CPT I deficiency can also have an enlarged liver, liver malfunction, and elevated levels of carnitine in the blood. Carnitine, a natural substance acquired mostly through the diet, is used by cells to process fats and produce energy. Individuals with CPT I deficiency are at risk for nervous system damage, liver failure, seizures, coma, and sudden death. | CPT I A is treated with dietary restrictions to avoid foods that their body cannot break down. Children often take MCT oil (medium chain triglycerides). This oil contains fats that they can break down for energy. |
| CPT II  
Carnitine palmitoyltransferase II | Rare | 0 | 42 | Carnitine palmitoyltransferase II (CPT II) deficiency is a condition that prevents the body from using certain fats for energy, particularly during periods without food. There are three main types of CPT II deficiency: a lethal neonatal form (18 families known), a severe infantile hepatic cardiovascular form (30 families known), and a myopathic form (<300 reported cases). | CPT-II is treated with dietary restrictions to avoid foods that their body cannot break down. Children often take MCT oil (medium chain triglycerides). This oil contains fats that they can break down for energy. |
| GA2  
Glutaric acidemia type II | Rare-Incidence unknown | 0 | 35 | Glutaric acidemia type II is an inherited disorder that interferes with the body's ability to break down proteins and fats to produce energy. Incompletely processed proteins and fats can build up in the body and cause the blood and tissues to become too acidic (metabolic acidosis). Glutaric acidemia type II usually appears in infancy or early childhood as a sudden episode called a metabolic crisis, in which acidosis and low blood sugar cause weakness, behavior changes such as poor feeding and decreased activity, and vomiting. These metabolic crises, which can be life-threatening, may be triggered by common childhood illnesses or other stresses. | Treatment includes a diet which avoids high fat foods. L-Carnitine supplementation to help break down fats may also be prescribed. Baby may also be prescribed riboflavin or glycine supplements. |
| MCAT  
Medium-chain ketoacyl-CoA thiolase deficiency | Rare, only 1 reported case | 0 | 17 | Medium-chain ketoacyl-CoA thiolase deficiency (MCAT) is a condition in which the body is unable to break down certain fats. It is considered a fatty acid oxidation condition because people affected by MCAT are unable to change some of the fats they eat into energy the body needs to function. This can cause too many unused fatty acids build up in the body. If left untreated, MCAT can cause vomiting, liver problems, and death. The effectiveness of treatment is unknown. | Treatment includes immediate use of IV fluids to lower acid levels in the bloodstream. |
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Incidence</th>
<th>0</th>
<th>26</th>
<th>3-hydroxyacyl-CoA dehydrogenase deficiency is an inherited condition that prevents the body from converting certain fats to energy, particularly during prolonged periods without food.</th>
<th>Treatment includes a diet which avoids high fat foods. L-Carnitine supplementation to help break down fats may also be prescribed. Babies may also be prescribed riboflavin or glycine supplements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M/SCHAD 3-hydroxyacyl-CoA dehydrogenase deficiency (Medium/short chain L-3 hydroxyacyl-CoA dehydrogenase deficiency)</td>
<td>Incidence is unknown</td>
<td>0</td>
<td>26</td>
<td>3-hydroxyacyl-CoA dehydrogenase deficiency is an inherited condition that prevents the body from converting certain fats to energy, particularly during prolonged periods without food.</td>
<td>Treatment includes a diet which avoids high fat foods. L-Carnitine supplementation to help break down fats may also be prescribed. Babies may also be prescribed riboflavin or glycine supplements.</td>
</tr>
<tr>
<td>SCAD Short-chain acyl-CoA dehydrogenase deficiency</td>
<td>1:40,000 - 1:100,000</td>
<td>1</td>
<td>32</td>
<td>Short-chain acyl-CoA dehydrogenase deficiency (SCAD) is a condition in which the body is unable to break down certain fats. SCAD is considered a fatty acid oxidation condition because people affected by the condition are unable to change some of the fats they eat into energy the body needs to function. Most individuals who are identified as having SCAD never experience symptoms, while some individuals experience serious health effects. Detecting the condition early and beginning treatment may help prevent many of the serious outcomes of SCAD.</td>
<td>Treatment includes a diet which avoids high fat foods. L-Carnitine supplementation to help break down fats may also be prescribed. Baby may also be prescribed riboflavin or glycine supplements.</td>
</tr>
<tr>
<td>ARG Arginase deficiency (Argininemia)</td>
<td>1:300,000 - 1:1,000,000</td>
<td>0</td>
<td>36</td>
<td>Arginase deficiency is an inherited urea cycle disorder that causes the amino acid arginine (a building block of proteins) and ammonia to accumulate gradually in the blood. Ammonia, which is formed when proteins are broken down in the body, is toxic if levels become too high. The nervous system is especially sensitive to the effects of excess ammonia.</td>
<td>Treatment includes a diet that avoids proteins that the body cannot break down. Diet may include special formulas for children with ARG.</td>
</tr>
<tr>
<td>H-PHE Benign hyperphenylalaninemia</td>
<td>15-75: 1,000,000</td>
<td>0</td>
<td>32</td>
<td>Benign hyperphenylalaninemia</td>
<td>Treatment is not usually needed, but some may need to limit phenylalanine in their diet.</td>
</tr>
<tr>
<td>BIOPT-REG Tetrahydrobiopterin deficiency (Biopterin defect in cofactor regeneration)</td>
<td>1:500,000-million</td>
<td>0</td>
<td>19</td>
<td>Tetrahydrobiopterin deficiency is a rare disorder characterized by a shortage of a molecule called tetrahydrobiopterin or BH4. This condition alters the levels of several substances in the body, including phenylalanine. Phenylalanine is a building block of proteins (an amino acid) that is obtained through the diet. It is found in foods that contain protein and in some artificial sweeteners. High levels of phenylalanine are present from early infancy in people with untreated tetrahydrobiopterin deficiency. This condition also alters the levels of chemicals called neurotransmitters, which transmit signals between nerve cells in the brain. Infants with this deficiency appear normal at birth, but medical problems ranging from mild to severe become apparent over time. Signs and symptoms can include intellectual disability, progressive problems with development, movement disorders, difficulty swallowing, seizures, behavioral problems, and an inability to control body temperature.</td>
<td>Treatment of tetrahydrobiopterin deficiency is focused on managing the symptoms and preventing long-term nervous system damage. Treatment may include a low-phenylalanine diet, supplementation with tetrahydrobiopterin and neurotransmitters, and other medications to help treat symptoms.</td>
</tr>
<tr>
<td>BIOPT-BS Tetrahydrobiopterin deficiency (Biopterin defect in cofactor biosynthesis)</td>
<td>1:500,000-1,000,000</td>
<td>0</td>
<td>18</td>
<td>Tetrahydrobiopterin deficiency is a rare disorder characterized by a shortage of a molecule called tetrahydrobiopterin or BH4. This condition alters the levels of several substances in the body, including phenylalanine. Phenylalanine is a building block of proteins (an amino acid) that is obtained through the diet. It is found in foods that contain protein and in some artificial sweeteners. High levels of phenylalanine are present from early infancy in people with untreated tetrahydrobiopterin deficiency. This condition also alters the levels of chemicals called neurotransmitters, which transmit signals between nerve cells in the brain. Infants with this deficiency appear normal at birth, but medical problems ranging from mild to severe become apparent over time. Signs and symptoms can include intellectual disability, progressive problems with development, movement disorders, difficulty swallowing, seizures, behavioral problems, and an inability to control body temperature.</td>
<td>Treatment of tetrahydrobiopterin deficiency is focused on managing the symptoms and preventing long-term nervous system damage. Treatment may include a low-phenylalanine diet, supplementation with tetrahydrobiopterin and neurotransmitters, and other medications to help treat symptoms.</td>
</tr>
<tr>
<td>CIT II</td>
<td>Citrullinemia</td>
<td>1:100,000-11:230,000</td>
<td>0</td>
<td>Primarily Japanese</td>
<td>35</td>
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</tr>
<tr>
<td>MET</td>
<td>Hypermethioninemia</td>
<td>unknown</td>
<td>0</td>
<td>33</td>
<td>Hypermethioninemia (MET) is a condition that occurs when there is a high amount of methionine in the body. It is considered an amino acid condition because people with MET are unable to break down an amino acid, a building block of proteins, known as methionine. Many people with MET do not show signs of the condition. However, if MET is untreated, it can cause learning delays, muscle weakness, and other health problems in some affected individuals.</td>
</tr>
<tr>
<td>TYR II</td>
<td>Tyrosinemia type II</td>
<td>1:250,000</td>
<td>0</td>
<td>36</td>
<td>Tyrosinemia is a genetic disorder characterized by disruptions in the multistep process that breaks down the amino acid tyrosine, a building block of most proteins. If untreated, tyrosine and its byproducts build up in tissues and organs, which can lead to serious health problems. Tyrosinemia type II can affect the eyes, skin, and mental development. Signs and symptoms often begin in early childhood and include eye pain and redness, excessive tearing, abnormal sensitivity to light, and thick, painful skin on the palms of their hands and soles of their feet. About 50 percent of individuals with tyrosinemia type II have some degree of intellectual disability.</td>
</tr>
<tr>
<td>TYR III</td>
<td>Tyrosinemia type III</td>
<td>Rare</td>
<td>0</td>
<td>30</td>
<td>Tyrosinemia type III is the rarest of the three types. The characteristic features of this type include intellectual disability, seizures, and periodic loss of balance and coordination (intermittent ataxia).</td>
</tr>
<tr>
<td>Var Hb</td>
<td>Hemoglobinopathies</td>
<td>1:20,000</td>
<td>3-4</td>
<td>40</td>
<td>Hemoglobinopathies are inherited conditions that affect the number or shape of the red blood cells in the body. These conditions can be very different from one another. Some hemoglobinopathies can cause life-threatening symptoms, while others do not cause medical problems. Hemoglobinopathies are treated with medications, blood transfusion, and IV fluid hydration as needed. Daily antibiotic use may be used to prevent infections.</td>
</tr>
</tbody>
</table>
or even signs of the condition. Mild hemoglobinopathies may require no medical treatment. However, when severe cases are left untreated, they can cause a shortage of red blood cells (anemia), organ damage or even death. Fortunately, when severe hemoglobinopathies are identified and treated early in life, affected children often can lead healthy lives.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency</th>
<th>Age</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Galactoseimperase deficiency</strong></td>
<td>Very rare, unknown</td>
<td>0</td>
<td>Immediate dietary treatment is needed. Avoidance of foods with galactose (a sugar found in milk) to prevent toxic build-up of undigested sugars in the blood. Lifelong avoidance of food and formulas that contain galactose is required. Avoid all milk products and fruits/vegetables that contain galactose.</td>
</tr>
<tr>
<td><strong>Galactokinase deficiency</strong></td>
<td>&lt;1:100,000</td>
<td>&lt;1</td>
<td>The treatment is dietary therapy, which involves taking calcium supplements and restricting galactose in the diet throughout life to prevent cataracts.</td>
</tr>
<tr>
<td><strong>T-cell other</strong> (T-cell related lymphocyte deficiency)</td>
<td>5:100,000</td>
<td>3-4</td>
<td>Treatments can vary from avoidance of illnesses, to immunoglobulin replacement therapies to bone marrow or thymus transplant.</td>
</tr>
</tbody>
</table>

**Notes:**
* Includes Washington DC, Guam and Puerto Rico
Core conditions in bold, Secondary in italic
R9-13-201. Definitions

In this Article, unless otherwise specified:

1. “Abnormal result” means an outcome that deviates from the range of values established by:
   a. The Department for an analysis performed as part of a bloodspot test or for a hearing test, or
   b. A health care facility or health care provider for critical congenital heart defect screening.

2. “Admission” or “admitted” means the same as in A.A.C. R9-10-101.


4. “Argininosuccinic acidemia” means a congenital disorder characterized by an inability to metabolize the amino acid argininosuccinic acid due to defective argininosuccinate lyase activity.

5. “Arizona State Laboratory” means the entity operated according to A.R.S. § 36-251.

6. “Audiological equipment” means an instrument used to help determine the presence, type, or degree of hearing loss by:
   a. Providing ear-specific and frequency-specific stimuli to an individual; or
   b. Measuring an individual’s physiological response to stimuli.

7. “Audiologist” means the same as in A.R.S. § 36-1901.

8. “Beta-ketothiolase deficiency” means a congenital disorder characterized by an inability to metabolize 2-methyl-acetoacetyl-CoA due to defective mitochondrial acetoacetil-CoA thiolase activity.

9. “Biotinidase deficiency” means a congenital disorder characterized by defective biotinidase activity that causes abnormal biotin metabolism.

10. “Birth center” means a health care facility that is not a hospital and is organized for the purpose of delivering newborns.

11. “Blood sample” means capillary or venous blood, but not cord blood, applied to the filter paper of a specimen collection kit.

12. “Bloodspot test” means multiple laboratory analyses performed on a blood sample to screen for the presence of congenital disorders listed in R9-13-203.
13. “Carnitine uptake defect” means a congenital disorder characterized by a decrease in the amount of free carnitine due to defective sodium ion-dependent carnitine transporter OCTN2 activity.

14. “Citrullinemia” means a congenital disorder characterized by an inability to convert the amino acid citrulline and aspartic acid into argininosuccinic acid due to defective argininosuccinate synthetase activity.

15. “Classic galactosemia” means a congenital disorder characterized by abnormal galactose metabolism due to defective galactose-1-phosphate uridyltranferase activity.

16. “Congenital adrenal hyperplasia” means a congenital disorder characterized by decreased cortisol production and increased androgen production due to defective 21-hydroxylase activity.

17. “Congenital disorder” means an abnormal condition present at birth, as a result of heredity or environmental factors, that impairs normal physiological functioning of a human body.

18. “Congenital hypothyroidism” means a congenital disorder characterized by deficient thyroid hormone production.

19. “Critical congenital heart defect” means a heart abnormality or condition present at birth that places a newborn or infant at significant risk of disability or death if not diagnosed soon after birth.

20. “Cystic fibrosis” means a congenital disorder caused by defective functioning of a transmembrane regulator protein and characterized by damage to and dysfunction of various organs, such as the lungs, pancreas, and reproductive organs.


22. “Diagnostic evaluation” means a hearing test performed by an audiologist or a physician to determine whether hearing loss exists, and, if applicable, determine the type or degree of hearing loss.

23. “Discharge” means the termination of inpatient services to a newborn or an infant.

24. “Disorder” means a disease or medical condition that may be identified by a laboratory analysis.

25. “Document” means to establish and maintain information in written, photographic, electronic, or other permanent form.

26. “Educational materials” means printed or electronic information provided by the Department, explaining newborn and infant screening, any of the congenital disorders listed in R9-13-203, hearing loss, or critical congenital heart defect.
27. “Electronic” means the same as in A.R.S. § 44-7002.
28. “First specimen” means the initial specimen that is collected from a newborn who is less than five days of age and sent to the Arizona State Laboratory for testing and recording of demographic information.
29. “Glutaric acidemia type I” means a congenital disorder characterized by an accumulation of glutaric acid due to defective glutaryl-CoA dehydrogenase activity.
30. “Guardian” means an individual appointed by a court under A.R.S. Title 14, Chapter 5, Article 2.
31. “Health care facility” means a health care institution defined in A.R.S. § 36-401 where obstetrical care or newborn care is provided.
32. “Health care provider” means a physician, physician assistant, registered nurse practitioner, or midwife.
33. “Health-related services” means the same as in A.R.S. § 36-401.
34. “Hearing screening” means a hearing test to determine the likelihood of hearing loss in a newborn or infant.
35. “Hearing test” means an evaluation of each of a newborn’s or an infant’s ears, using audiological equipment to:
   a. Screen the newborn or infant for a possible hearing loss;
   b. Determine that the newborn or infant does not have a hearing loss; or
   c. Diagnose a hearing loss in the newborn or infant, including determining the type or degree of hearing loss.
36. “Hemoglobin S/Beta-thalassemia” means a sickle cell disease in which an individual has one sickle cell gene and one gene for beta thalassemia, another inherited hemoglobinopathy.
37. “Hemoglobin S/C disease” means a sickle cell disease in which an individual has one sickle cell gene and one gene for another inherited hemoglobinopathy called hemoglobin C.
38. “Hemoglobinopathy” means a congenital disorder characterized by abnormal production, structure, or functioning of hemoglobin.
39. “Home birth” means delivery of a newborn, outside a health care facility, when the newborn is not hospitalized within 72 hours of delivery.
40. “Homocystinuria” means a congenital disorder characterized by abnormal methionine and homocysteine metabolism due to defective cystathione-β-synthase activity.
41. “Hospital” means the same as in A.A.C. R9-10-101.
42. “Hospital services” means the same as in A.A.C. R9-10-201.

43. “3-Hydroxy-3-methylglutaric aciduria” means a congenital disorder characterized by the accumulation of 3-hydroxy-3-methylglutaric acid due to a defective 3-hydroxy-3-methylglutaryl-CoA lyase activity.

44. “Identification code” means a unique set of numbers or letters, or a unique set of both numbers and letters, assigned by the Department to a health care facility, a health care provider, an audiologist, or another person submitting specimen collection kits to the Arizona State Laboratory or hearing test results to the Department.

45. “Infant” means the same as in A.R.S. § 36-694.

46. “Inpatient” means an individual who:
   a. Is admitted to a hospital,
   b. Receives hospital services for 24 consecutive hours, or
   c. Is admitted to a birth center.

47. “Inpatient services” means medical services, nursing services, or other health-related services provided to an inpatient in a health care facility.

48. “Isovaleric acidemia” means a congenital disorder characterized by an accumulation of isovaleric acid due to defective isovaleryl-CoA dehydrogenase activity.

49. “Long-chain 3-hydroxy acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 16 carbon atoms in length due to defective long-chain 3-hydroxy acyl-CoA dehydrogenase activity.

50. “Maple syrup urine disease” means a congenital disorder of branched chain amino acid metabolism due to defective branched chain-keto acid dehydrogenase activity.

51. “Medical services” means the same as in A.R.S. § 36-401.

52. “Medium chain acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 6 to 10 carbon atoms in length due to defective medium-chain acyl-CoA dehydrogenase activity.

53. “3-Methylcrotonyl-CoA carboxylase deficiency” means a congenital disorder characterized by an accumulation of 3-methylcrotonyl-glycine due to defective 3-methylcrotonyl-CoA carboxylase activity.

54. “Methylmalonic acidemia (Cbl A,B)” means a congenital disorder characterized by an accumulation of methylmalonic acid due to defective activity of methylmalonyl-CoA racemase or adenosylcobalamin synthetase.
55. “Methylmalonic acidemia (mutase deficiency)” means a congenital disorder characterized by an accumulation of methylmalonic acid due to defective methylmalonyl-CoA mutase activity.

56. “Midwife” means an individual licensed under A.R.S. Title 36, Chapter 6, Article 7, or certified under A.R.S. Title 32, Chapter 15.

57. “Multiple carboxylase deficiency” means a congenital disorder characterized by an inability to transport or metabolize biotin that leads to defective activity of propionyl-CoA carboxylase, beta-methylcrotonyl-CoA carboxylase, and pyruvate carboxylase.

58. “Newborn” means the same as in A.R.S. § 36-694.

59. “Newborn care” means medical services, nursing services, and health-related services provided to a newborn.

60. “Nursing services” means the same as in A.R.S. § 36-401.

61. “Obstetrical care” means medical services, nursing services, and health-related services provided to a woman throughout her pregnancy, labor, delivery, and postpartum.

62. “Organ” means a somewhat independent part of a human body, such as a salivary gland, kidney, or pancreas, which performs a specific function.

63. “Parent” means a natural, adoptive, or custodial mother or father of a newborn or an infant.

64. “Parenteral nutrition” means the feeding of an individual intravenously through the administration of a formula containing glucose, amino acids, lipids, vitamins, and minerals.

65. “Person” means the state, a municipality, district, or other political subdivision, a cooperative, institution, corporation, company, firm, partnership, individual, or other legal entity.

66. “Phenylketonuria” means a congenital disorder characterized by abnormal phenylalanine metabolism due to defective phenylalanine hydroxylase activity.

67. “Physician” means an individual licensed under A.R.S. Title 32, Chapters 13, 14, 17, or 29.

68. “Physician assistant” means an individual licensed under A.R.S. Title 32, Chapter 25.

69. “Propionic acidemia” means a congenital disorder characterized by an accumulation of glycine and 3-hydroxypropionic acid due to defective propionyl-CoA carboxylase activity.

70. “Pulse oximetry” means a non-invasive method of measuring the percentage of hemoglobin in the blood that is saturated with oxygen using a device approved by the
U.S. Food and Drug Administration for use with newborns or infants less than six weeks of age.

71. “Registered nurse practitioner” means the same as in A.R.S. § 32-1601.

72. “Second specimen” means a specimen that is sent to the Arizona State Laboratory for testing and recording of demographic information, after being collected:
   a. From a newborn after a first specimen; or
   b. From an individual at least five days and not older than one year of age, regardless of whether a first specimen was collected.

73. “Severe combined immunodeficiency” means a congenital disorder usually characterized by a defect in both the T- and B-lymphocyte systems, which typically results in the onset of one or more serious infections within the first few months of life.

74. “Sickle cell anemia” means a sickle cell disease in which an individual has two sickle cell genes.

75. “Sickle cell disease” means a hemoglobinopathy characterized by an abnormally shaped red blood cell resulting from the abnormal structure of the protein hemoglobin.

76. “Sickle cell gene” means a unit of inheritance that is involved in producing an abnormal type of the protein hemoglobin, in which the amino acid valine is substituted for the amino acid glutamic acid at a specific location in the hemoglobin.

77. “Specimen” means a blood sample obtained from and demographic information about a newborn or an infant.

78. “Specimen collection kit” means a strip of filter paper for collecting a blood sample attached to a form for obtaining the information specified in R9-13-203(B)(3) about a newborn or an infant.

79. “Spinal muscular atrophy” means a congenital disorder characterized by the loss of nerve cells in the spinal cord that control muscle movement due to the deletion of exon 7 in the survival motor neuron 1 (SMN1) gene.

80. “Transfer” means a health care facility or health care provider discharging a newborn and sending the newborn to a hospital for inpatient medical services without the intent that the patient will be returned to the sending health care facility or health care provider.

81. “Transfusion” means the infusion of blood or blood products into the body of an individual.

82. “Trifunctional protein deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 12 to 18 carbon atoms in length due to defective mitochondrial trifunctional protein activity.
“Tyrosinemia type I” means a congenital disorder characterized by an accumulation of the amino acid tyrosine due to defective fumarylacetoacetate hydrolase activity.

“Verify” means to confirm by obtaining information through a source such as the newborn screening program, a health care provider, a health care facility, or a documented record.

“Very long-chain acyl-CoA dehydrogenase deficiency” means a congenital disorder characterized by an inability to metabolize fatty acids that are 14 to 18 carbon atoms in length due to defective very long-chain acyl-CoA dehydrogenase activity.

“Working day” means 8:00 a.m. through 5:00 p.m. Monday through Friday, excluding state holidays.

“X-linked adrenoleukodystrophy” means a congenital disorder characterized by the build-up in the body of very long-chain fatty acids due to a deficiency in the amount of adrenoleukodystrophy protein, caused by a defective ABCD1 gene.

R9-13-202. Newborn and Infant Critical Congenital Heart Defect Screening

A. A health care facility’s designee, a health care provider, or a health care provider’s designee shall order critical congenital heart defect screening using pulse oximetry for a newborn to be performed:
   1. Between 24 and 48 hours after birth according to the health care facility’s or health care provider’s policies and procedures, or
   2. As late as possible before discharge according to the health care facility’s or health care provider’s policies and procedures if the newborn is discharged earlier than 24 hours after birth.

B. Before critical congenital heart defect screening is performed on a newborn, a health care facility’s designee, a health care provider, or a health care provider’s designee shall provide educational materials to the newborn’s parent or guardian.

C. When critical congenital heart defect screening is ordered for a newborn, a health care facility’s designee, a health care provider, or a health care provider’s designee shall submit, in a format specified by the Department, the following information:
   1. The newborn’s name, gender, race, ethnicity, medical record number, and, if applicable, AHCCCS identification number;
   2. Whether the newborn is from a single or multiple birth;
   3. If the newborn is from a multiple birth, the birth order of the newborn;
   4. The date and time of birth, and the newborn’s weight at birth;
5. The identification code or the name and address of the health care facility or health care provider submitting the information;

6. Except as provided in subsection (C)(7), the mother’s first and last names, date of birth, name before first marriage, mailing address, telephone number, and, if applicable, AHCCCS identification number;

7. If the newborn’s mother does not have physical custody of the newborn, the first and last names, mailing address, and telephone number of the person who has physical custody of the newborn;

8. The date, time, and result of the critical congenital heart defect screening;

9. If critical congenital heart defect screening was not performed, the reason critical congenital heart defect screening was not performed;

10. If the newborn was transferred to another health care facility or health care provider before the critical congenital heart defect screening was performed, the name, address, and telephone number of the health care facility or health care provider to which the newborn was transferred; and

11. Whether the newborn has a medical condition that may affect the critical congenital heart defect screening results.

D. In addition to the information in subsection (C), if the reported result of critical congenital heart defect screening for a newborn or infant is abnormal, a health care facility’s designee, a health care provider, or a health care provider’s designee shall submit to the Department, upon request and in a format specified by the Department, the following information:

1. The dates, times, values of all critical congenital heart defect screening results;

2. The dates, times, and results of any subsequent tests performed as a result of critical congenital heart defect screening;

3. The name, address, and telephone number of the contact person for the health care facility, health care provider, or other person performing the subsequent tests; and

4. If a medical condition is found as a result of critical congenital heart defect screening or subsequent tests, the type of medical condition found and the name of the health care provider who will be responsible for the coordination of medical services for the newborn or infant after the newborn or infant is discharged.

R9-13-203. Newborn and Infant Bloodspot Tests

A. A bloodspot test shall screen for the following congenital disorders:

1. 3-Hydroxy-3-methylglutaric aciduria,
2. 3-Methylcrotonyl-CoA carboxylase deficiency,  
3. Argininosuccinic acidemia,  
4. Beta-ketothiolase deficiency,  
5. Biotinidase deficiency,  
6. Carnitine uptake defect,  
7. Citrullinemia,  
8. Classic galactosemia,  
9. Congenital adrenal hyperplasia,  
10. Congenital hypothyroidism,  
11. Cystic fibrosis,  
12. Glutaric acidemia type I,  
13. Hemoglobin S/Beta-thalassemia,  
14. Hemoglobin S/C disease,  
15. Homocystinuria,  
16. Isovaleric acidemia,  
17. Long-chain 3-hydroxy acyl-CoA dehydrogenase deficiency,  
18. Maple syrup urine disease,  
19. Medium chain acyl-CoA dehydrogenase deficiency,  
20. Methylmalonic acidemia (Cbl A,B),  
21. Methylmalonic acidemia (mutase deficiency),  
22. Multiple carboxylase deficiency,  
23. Phenylketonuria,  
24. Propionic acidemia,  
25. Severe combined immunodeficiency,  
26. Sickle cell anemia,  
27. Spinal muscular atrophy,  
28. Trifunctional protein deficiency,  
29. Tyrosinemia type I, and  
30. Very long-chain acyl-CoA dehydrogenase deficiency, and  
31. X-linked adrenoleukodystrophy.

B. When a bloodspot test is ordered for a newborn or an infant, a health care facility’s designee, a health care provider, or the health care provider’s designee shall:
1. Only use a specimen collection kit supplied by the Department;  
2. Collect a blood sample from the newborn or infant on a specimen collection kit;
3. Complete the following information on the specimen collection kit:
   a. The newborn’s or infant’s name, gender, race, ethnicity, medical record number, and, if applicable, AHCCCS identification number;
   b. The newborn’s or infant’s type of food or food source;
   c. Whether the newborn or infant is from a single or multiple birth;
   d. If the newborn or infant is from a multiple birth, the birth order of the newborn or infant;
   e. Whether the newborn or infant has a medical condition that may affect the bloodspot test results;
   f. Whether the newborn or infant received a blood transfusion and, if applicable, the date of the last blood transfusion;
   g. The date and time of birth, and the newborn’s or infant’s weight at birth;
   h. The date and time of blood sample collection, and the newborn’s or infant’s weight when the blood sample is collected;
   i. The identification code or the name and address of the health care facility or health care provider submitting the specimen collection kit;
   j. The name, address, and telephone number or the identification code of the health care provider responsible for the management of medical services provided to the newborn or infant;
   k. Except as provided in subsection (B)(3)(l), the mother’s first and last names, date of birth, name before first marriage, mailing address, telephone number, and if applicable, AHCCCS identification number; and
   l. If the newborn’s or infant’s mother does not have physical custody of the newborn or infant, the first and last names, mailing address, and telephone number of the person who has physical custody of the newborn or infant; and

4. Submit the specimen collection kit to the Arizona State Laboratory no later than 24 hours or the next working day after the blood sample is collected.

C. A health care facility or a health care provider submitting a first specimen to the Arizona State Laboratory shall pay the Department the fee in R9-13-208(A).

D. A person who submits a second specimen to the Arizona State Laboratory shall:
   1. Pay the fee in R9-13-208(B) to the Department, or
   2. Provide the following information to the Arizona State Laboratory for billing purposes:
      a. The name, mailing address, and telephone number of the newborn’s or infant’s parent or the individual responsible for paying, if not the parent; and
b. If the individual responsible for paying has health care insurance for the newborn or infant, information about the health care insurance, including:
   i. The policyholder’s name;
   ii. The name and billing address of the health care insurance company;
   iii. The member identification number;
   iv. The group number, if applicable; and
   v. The effective date of the health care insurance; or

c. That the individual responsible for paying has no health care insurance for the newborn or infant.

E. When a health care insurance company or an individual responsible for paying is identified as specified in subsection (D)(2), the health care insurance company or the individual responsible for paying shall pay the Department the fee in R9-13-208(B).

F. When a home birth not attended by a health care provider is reported to a local registrar, a deputy local registrar, or the state registrar under A.R.S. § 36-333:
   1. The local registrar, deputy local registrar, or state registrar shall notify the local health department of the county where the birth occurred; and
   2. The local health department’s designee shall collect a specimen from the newborn or infant according to the requirements in R9-13-204(A)(2) or R9-13-205(C).

G. A health care facility’s designee, a health care provider, or the health care provider’s designee shall ensure that:
   1. Educational materials are provided to the parent or guardian of a newborn or an infant for whom a bloodspot test is ordered, and
   2. The newborn’s or infant’s parent or guardian is informed of the requirement for a second specimen if the second specimen has not been collected.

H. For a home birth, a health care provider or the health care provider’s designee shall provide educational materials to the parent or guardian of a newborn or an infant for whom a bloodspot test is ordered.

R9-13-204. First Specimen Collection

A. When a newborn is born in a hospital, the hospital’s designee shall collect a first specimen from the newborn according to whichever of the following occurs first:
   1. Unless specified otherwise by a physician, physician assistant, or registered nurse practitioner, before administering a transfusion or parenteral nutrition;
   2. When the newborn is at least 24 but not more than 72 hours old; or
3. Before the newborn is discharged, unless the newborn:
   a. Is transferred to another hospital before the newborn is 48 hours old; or
   b. Dies before the newborn is 72 hours old.

B. If a newborn is admitted or transferred to a hospital before the newborn is 48 hours old, the
   receiving hospital’s designee shall:
   1. Verify that the first specimen was collected before admission or transfer, or
   2. Collect a first specimen from the newborn according to the requirements in subsection
      (A).

C. When a newborn is born in a birth center, the birth center’s designee shall collect a first specimen
   from the newborn according to sub-sections (A)(1) or (A)(2).

D. For a home birth attended by a health care provider, the health care provider or the health care
   provider’s designee shall collect a first specimen from the newborn according the requirements in
   subsection (A)(2).

R9-13-205. Second Specimen Collection

A. After a newborn’s or an infant’s discharge from a health care facility or after a home birth, a
   health care provider or the health care provider’s designee shall:
   1. Collect a second specimen from the newborn or infant not older than one year of age at
      the time of the newborn’s or infant’s first visit to the health care provider, or
   2. Verify that a health care facility or different health care provider has collected a second
      specimen from the newborn or infant.

B. If a newborn is an inpatient of a health care facility at 5 days of age, the health care facility’s
   designee shall collect a second specimen from the newborn:
   1. When the newborn is at least 5 but not more than 10 days old; or
   2. If the newborn is discharged from the health care facility when the newborn is at least 5
      but not more than 10 days old, before discharge.

C. For a home birth that is not attended by a health care provider, a local health department’s
   designee shall collect a specimen from a newborn or an infant if the local health department’s
   designee has not verified that a second specimen has already been collected from the newborn or
   infant.

R9-13-206. Reporting Requirements for Specimens

A. The Arizona State Laboratory shall report, in written or electronic format, to the health care
   provider and, if applicable, health care facility identified on a specimen collection kit:
1. The results of a bloodspot test on a specimen; or
2. For a specimen that does not meet quality standards established by the Arizona State Laboratory in compliance with 42 CFR § 493.1200:
   a. That a bloodspot test was not performed on the specimen; and
   b. The reason the bloodspot test was not performed.

B. A health care facility’s designee, a health care provider, or the health care provider’s designee, who orders a subsequent test on a newborn or an infant in response to an abnormal result on a bloodspot test, shall send the results of the subsequent test in writing to the Department, if the subsequent test is not performed by the Arizona State Laboratory.

C. Bloodspot test results are confidential subject to the disclosure provisions of 9 A.A.C. 1, Article 3, and A.R.S. §§ 12-2801 and 12-2802.

R9-13-207. Newborn and Infant Hearing Tests

A. Before a hearing test is performed on a newborn or infant, a health care facility’s designee, a health care provider, or the health care provider’s designee shall provide educational materials to the newborn’s or infant’s parent or guardian.

B. A health care facility’s designee, a health care provider, or the health care provider’s designee shall order hearing testing for a newborn or infant to be performed according to the health care facility’s or health care provider’s policies and procedures that includes:
   1. An initial hearing screening ordered to be performed within 30 days after birth or before discharge;
   2. A second hearing screening ordered to be performed within 30 days after birth if an abnormal result is obtained in one or both of a newborn’s or infant’s ears on the initial hearing screening; and
   3. Diagnostic evaluation ordered to be performed:
      a. If a newborn or infant has an abnormal result in one or both ears on the second hearing screening;
      b. If a newborn or infant has been admitted to the Neonatal Intensive Care Unit for five days or more and has an abnormal initial hearing screening;
      c. If a newborn or infant has a medical condition that makes diagnostic evaluation more appropriate; or
      d. As clinically indicated.
C. When an initial hearing test is performed on a newborn or infant, a health care facility’s designee, a health care provider, or the health care provider’s designee shall submit to the Department, as specified in subsection (G), the following information:
   1. The newborn’s or infant’s name, date of birth, gender, and medical record number;
   2. Whether the newborn or infant is from a single or multiple birth;
   3. If the newborn or infant is from a multiple birth, the birth order of the newborn or infant;
   4. The first and last names and date of birth of the newborn’s or infant’s mother;
   5. The name and identification code of the health care facility of birth;
   6. The name and identification code of the health care facility where the initial hearing test was performed or of the health care provider who performed the initial hearing test;
   7. The date of the initial hearing test;
   8. Whether or not the initial hearing test was performed when the newborn or infant was an inpatient;
   9. The audiological equipment used for the initial hearing test and the type of initial hearing test performed; and
   10. The initial hearing test result for each of the newborn’s or infant’s ears.

D. In addition to the information in subsection (C), if the reported results of an initial hearing test on a newborn or infant include an abnormal result, a health care facility’s designee, a health care provider, or the health care provider’s designee shall submit to the Department, as specified in subsection (G), the following information:
   1. Except as provided in subsection (D)(2), the mother’s name before first marriage, mailing address, and telephone number;
   2. If the newborn’s or infant’s mother does not have physical custody of the newborn or infant, the first and last names, mailing address, and telephone number of the person who has physical custody of the newborn or infant;
   3. The name of the health care provider who will be responsible for the coordination of medical services for the newborn or infant after the newborn or infant is discharged from the health care facility;
   4. The name and telephone number of the person to whom the newborn’s or infant’s mother or other person who has physical custody of the newborn or infant was referred for a subsequent hearing test;
   5. The date of the appointment for a subsequent hearing test, if available; and
6. The health care facility where a subsequent hearing test is scheduled to be performed or
the name and address of the health care provider who is scheduled to perform the
subsequent test, if available.

E. When a subsequent hearing test is performed on a newborn or an infant after an initial hearing
test, the designee of the health care facility, health care provider, or other person that performs the
subsequent hearing test shall submit to the Department, as specified in subsection (G), the
following information:

1. The newborn’s or infant’s name, date of birth, and gender;
2. Whether the newborn or infant is from a single or multiple birth;
3. If the newborn or infant is from a multiple birth, the birth order of the newborn or infant;
4. The first and last names and date of birth of the newborn’s or infant’s mother;
5. The name of the health care facility of birth, if known;
6. The name of the health care facility where the subsequent hearing test was performed, or
the name and address of the health care provider who performed the subsequent hearing
test;
7. The date of the subsequent hearing test;
8. The audiological equipment used for the subsequent hearing test and type of hearing test
performed;
9. The result, including a quantitative result if applicable, for each of the newborn’s or
infant’s ears on the subsequent hearing test;
10. The name, address and telephone number of the contact person for the health care
facility, health care provider, or other person that performed the subsequent hearing test,
if different from the person specified in subsection (E)(6); and
11. If the subsequent hearing test was a diagnostic evaluation:
   a. Whether the newborn or infant has a hearing loss and, if so, the type and degree
      of hearing loss;
   b. A copy of the narrative that describes the hearing test performed on the newborn
      or infant to determine that the newborn or infant does not have a hearing loss or
diagnose a hearing loss in the newborn or infant, the results of the hearing test,
and the analysis of the hearing test results by the audiologist or physician who
performed the hearing test;
   c. Whether the newborn or infant has a medical condition that may affect the
      hearing test results; and
d. Whether the newborn or infant has been referred to early intervention services, including a date of referral.

F. In addition to the information in subsection (E), if the reported results of a subsequent hearing test on a newborn or infant include an abnormal result, the person submitting the report on the subsequent hearing test shall submit to the Department, as specified in subsection (G), the following information:

1. Except as provided in subsection (F)(2), the mailing address and telephone number of the newborn’s or infant’s mother;
2. If the newborn’s or infant’s mother does not have physical custody of the newborn or infant, the first and last names, mailing address, and telephone number of the person who has physical custody of the newborn or infant;
3. The name of the health care provider who is responsible for the coordination of medical services for the newborn or infant; and
4. If applicable, the name and phone telephone number of the person to whom the newborn’s or infant’s parent was referred for further hearing tests, evaluation services, specialty care, or early intervention.

G. A health care facility’s designee, health care provider, health care provider’s designee, or other person required to report under subsections (C), (D), (E), or (F) shall submit, in an electronic format specified by the Department, the information specified in subsections (C), (D), (E), or (F) for hearing tests performed each week by the sixth day of the subsequent week.

R9-13-208. Fees

A. The fee for a first specimen is $36.00.
B. The fee for a second specimen is $65.00.
36-132. Department of health services; functions; contracts

A. The department, in addition to other powers and duties vested in it by law, shall:

1. Protect the health of the people of the state.

2. Promote the development, maintenance, efficiency and effectiveness of local health departments or districts of sufficient population and area that they can be sustained with reasonable economy and efficient administration, provide technical consultation and assistance to local health departments or districts, provide financial assistance to local health departments or districts and services that meet minimum standards of personnel and performance and in accordance with a plan and budget submitted by the local health department or districts to the department for approval, and recommend the qualifications of all personnel.

3. Collect, preserve, tabulate and interpret all information required by law in reference to births, deaths and all vital facts, and obtain, collect and preserve information relating to the health of the people of this state and the prevention of diseases as may be useful in the discharge of functions of the department not in conflict with chapter 3 of this title and sections 36-693, 36-694 and 39-122.

4. Operate such sanitariums, hospitals or other facilities assigned to the department by law or by the governor.

5. Conduct a statewide program of health education relevant to the powers and duties of the department, prepare educational materials and disseminate information as to conditions affecting health, including basic information for the promotion of good health on the part of individuals and communities, and prepare and disseminate technical information concerning public health to the health professions, local health officials and hospitals. In cooperation with the department of education, the department of health services shall prepare and disseminate materials and give technical assistance for the purpose of education of children in hygiene, sanitation and personal and public health, and provide consultation and assistance in community organization to counties, communities and groups of people.

6. Administer or supervise a program of public health nursing, prescribe the minimum qualifications of all public health nurses engaged in official public health work, and encourage and aid in coordinating local public health nursing services.

7. Encourage and aid in coordinating local programs concerning control of preventable diseases in accordance with statewide plans that shall be formulated by the department.

8. Encourage and aid in coordinating local programs concerning maternal and child health, including midwifery, antepartum and postpartum care, infant and preschool health and the health of schoolchildren, including special fields such as the prevention of blindness and conservation of sight and hearing.

9. Encourage and aid in the coordination of local programs concerning nutrition of the people of this state.

10. Encourage, administer and provide dental health care services and aid in coordinating local programs concerning dental public health, in cooperation with the Arizona dental association. The department may bill and receive payment for costs associated with providing dental health care services and shall deposit the monies in the oral health fund established by section 36-138.

11. Establish and maintain adequate serological, bacteriological, parasitological, entomological and chemical laboratories with qualified assistants and facilities necessary for routine examinations and analyses and for investigations and research in matters affecting public health.

12. Supervise, inspect and enforce the rules concerning the operation of public bathing places and public and semipublic swimming pools adopted pursuant to section 36-136, subsection I, paragraph 10.

13. Take all actions necessary or appropriate to ensure that bottled water sold to the public and water used to process, store, handle, serve and transport food and drink are free from filth, disease-causing substances and organisms and unwholesome, poisonous, deleterious or other foreign substances. All state agencies and local health agencies involved with water quality shall provide to the department any assistance requested by the director to ensure that this paragraph is effectuated.
14. Enforce the state food, caustic alkali and acid laws in accordance with chapter 2, article 2 of this title, chapter 8, article 1 of this title and chapter 9, article 4 of this title, and collaborate in the enforcement of the federal food, drug, and cosmetic act (52 Stat. 1040; 21 United States Code sections 1 through 905).

15. Recruit and train personnel for state, local and district health departments.

16. Conduct continuing evaluations of state, local and district public health programs, study and appraise state health problems and develop broad plans for use by the department and for recommendation to other agencies, professions and local health departments for the best solution of these problems.

17. License and regulate health care institutions according to chapter 4 of this title.

18. Issue or direct the issuance of licenses and permits required by law.

19. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.

20. Subject to the availability of monies, develop and administer programs in perinatal health care, including:
   (a) Screening in early pregnancy for detecting high-risk conditions.
   (b) Comprehensive prenatal health care.
   (c) Maternity, delivery and postpartum care.
   (d) Perinatal consultation, including transportation of the pregnant woman to a perinatal care center when medically indicated.
   (e) Perinatal education oriented toward professionals and consumers, focusing on early detection and adequate intervention to avert premature labor and delivery.

21. License and regulate the health and safety of group homes for persons with developmental disabilities. The department shall issue a license to an accredited facility for a period of the accreditation, except that no licensing period shall be longer than three years. The department is authorized to conduct an inspection of an accredited facility to ensure that the facility meets health and safety licensure standards. The results of the accreditation survey shall be public information. A copy of the final accreditation report shall be filed with the department of health services. For the purposes of this paragraph, "accredited" means accredited by a nationally recognized accreditation organization.

B. The department may accept from the state or federal government, or any agency of the state or federal government, and from private donors, trusts, foundations or eleemosynary corporations or organizations grants or donations for or in aid of the construction or maintenance of any program, project, research or facility authorized by this title, or in aid of the extension or enforcement of any program, project or facility authorized, regulated or prohibited by this title, and enter into contracts with the federal government, or an agency of the federal government, and with private donors, trusts, foundations or eleemosynary corporations or organizations, to carry out such purposes. All monies made available under this section are special project grants. The department may also expend these monies to further applicable scientific research within this state.

C. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

D. The department may enter into contracts with organizations that perform nonrenal organ transplant operations and organizations that primarily assist in the management of end-stage renal disease and related problems to provide, as payors of last resort, prescription medications necessary to supplement treatment and transportation to and from treatment facilities. The contracts may provide for department payment of administrative costs it specifically authorizes.

36-136. **Powers and duties of director; compensation of personnel; rules; definitions**

A. The director shall:
1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.

C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director's behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.
2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. If in the director's opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.

F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

H. Notwithstanding subsection I, paragraph 1 of this section, the director may define and prescribe emergency measures for detecting, reporting, preventing and controlling communicable or infectious diseases or conditions if the director has reasonable cause to believe that a serious threat to public health and welfare exists. Emergency measures are effective for not longer than eighteen months.

I. The director, by rule, shall:

1. Define and prescribe reasonably necessary measures for detecting, reporting, preventing and controlling communicable and preventable diseases. The rules shall declare certain diseases reportable. The rules shall prescribe measures, including isolation or quarantine, that are reasonably required to prevent the occurrence of, or to seek early detection and alleviation of, disability, insofar as possible, from communicable or preventable diseases. The rules shall include reasonably necessary measures to control animal diseases transmittable to humans.

2. Define and prescribe reasonably necessary measures, in addition to those prescribed by law, regarding the preparation, embalming, cremation, interment, disinterment and transportation of dead human bodies and the conduct of funerals, relating to and restricted to communicable diseases and regarding the removal, transportation, cremation, interment or disinterment of any dead human body.

3. Define and prescribe reasonably necessary procedures that are not inconsistent with law in regard to the use and accessibility of vital records, delayed birth registration and the completion, change and amendment of vital records.

4. Except as relating to the beneficial use of wildlife meat by public institutions and charitable organizations pursuant to title 17, prescribe reasonably necessary measures to ensure that all food or drink, including meat and meat products and milk and milk products sold at the retail level, provided for human consumption is free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe reasonably necessary measures governing the production, processing, labeling, storing, handling, serving and transportation of these products. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained in any warehouse, restaurant or other premises, except a meat packing plant, slaughterhouse, wholesale meat processing plant, dairy product manufacturing plant or trade product manufacturing plant. The rules shall prescribe minimum standards for any truck or other vehicle in which food or drink is produced, processed, stored, handled, served or transported. The rules shall provide for the inspection and licensing of premises and vehicles so used, and for abatement as public nuisances of any premises or vehicles that do not comply with the rules and minimum standards. The rules shall provide an exemption relating to food or drink that is:

(a) Served at a noncommercial social event such as a potluck.

(b) Prepared at a cooking school that is conducted in an owner-occupied home.

(c) Not potentially hazardous and prepared in a kitchen of a private home for occasional sale or distribution for noncommercial purposes.

(d) Prepared or served at an employee-conducted function that lasts less than four hours and is not regularly scheduled, such as an employee recognition, an employee fundraising or an employee social event.

(e) Offered at a child care facility and limited to commercially prepackaged food that is not potentially hazardous and whole fruits and vegetables that are washed and cut on-site for immediate consumption.
(f) Offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous.

(g) A cottage food product that is not potentially hazardous or a time or temperature control for safety food and that is prepared in a kitchen of a private home for commercial purposes, including fruit jams and jellies, dry mixes made with ingredients from approved sources, honey, dry pasta and roasted nuts. Cottage food products must be packaged at home with an attached label that clearly states the name and registration number of the food preparer, lists all the ingredients in the product and the product's production date and includes the following statement: "This product was produced in a home kitchen that may process common food allergens and is not subject to public health inspection." If the product was made in a facility for individuals with developmental disabilities, the label must also disclose that fact. The person preparing the food or supervising the food preparation must complete a food handler training course from an accredited program and maintain active certification. The food preparer must register with an online registry established by the department pursuant to paragraph 13 of this subsection. The food preparer must display the preparer's certificate of registration when operating as a temporary food establishment. For the purposes of this subdivision, "not potentially hazardous" means cottage food products that meet the requirements of the food code published by the United States food and drug administration, as modified and incorporated by reference by the department by rule.

(h) A whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption.

(i) Produce in a packing or holding facility that is subject to the United States food and drug administration produce safety rule (21 Code of Federal Regulations part 112) as administered by the Arizona department of agriculture pursuant to title 3, chapter 3, article 4.1. For the purposes of this subdivision, "holding", "packing" and "produce" have the same meanings prescribed in section 3-525.

(j) Spirituous liquor produced on the premises licensed by the department of liquor licenses and control. This exemption includes both of the following:

(i) The area in which production and manufacturing of spirituous liquor occurs, as defined in an active basic permit on file with the United States alcohol and tobacco tax and trade bureau.

(ii) The area licensed by the department of liquor licenses and control as a microbrewery, farm winery or craft distiller that is open to the public and serves spirituous liquor and commercially prepackaged food, crackers or pretzels for consumption on the premises. A producer of spirituous liquor may not provide, allow or expose for common use any cup, glass or other receptacle used for drinking purposes. For the purposes of this item, "common use" means the use of a drinking receptacle for drinking purposes by or for more than one person without the receptacle being thoroughly cleansed and sanitized between consecutive uses by methods prescribed by or acceptable to the department.

5. Prescribe reasonably necessary measures to ensure that all meat and meat products for human consumption handled at the retail level are delivered in a manner and from sources approved by the Arizona department of agriculture and are free from unwholesome, poisonous or other foreign substances and filth, insects or disease-causing organisms. The rules shall prescribe standards for sanitary facilities to be used in identity, storage, handling and sale of all meat and meat products sold at the retail level.

6. Prescribe reasonably necessary measures regarding production, processing, labeling, handling, serving and transportation of bottled water to ensure that all bottled drinking water distributed for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions that shall be maintained at any source of water, bottling plant and truck or vehicle in which bottled water is produced, processed, stored or transported and shall provide for inspection and certification of bottled drinking water sources, plants, processes and transportation and for abatement as a public nuisance of any water supply, label, premises, equipment, process or vehicle that does not comply with the minimum standards. The rules shall prescribe minimum standards for bacteriological, physical and chemical quality for bottled water and for the submission of samples at intervals prescribed in the standards.

7. Define and prescribe reasonably necessary measures governing ice production, handling, storing and distribution to ensure that all ice sold or distributed for human consumption or for preserving or storing food for human consumption is free from unwholesome, poisonous, deleterious or other foreign substances and
filth or disease-causing organisms. The rules shall prescribe minimum standards for the sanitary facilities and conditions and the quality of ice that shall be maintained at any ice plant, storage and truck or vehicle in which ice is produced, stored, handled or transported and shall provide for inspection and licensing of the premises and vehicles, and for abatement as public nuisances of ice, premises, equipment, processes or vehicles that do not comply with the minimum standards.

8. Define and prescribe reasonably necessary measures concerning sewage and excreta disposal, garbage and trash collection, storage and disposal, and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels. The rules shall prescribe minimum standards for preparing food in community kitchens, adequacy of excreta disposal, garbage and trash collection, storage and disposal and water supply for recreational and summer camps, campgrounds, motels, tourist courts, trailer coach parks and hotels and shall provide for inspection of these premises and for abatement as public nuisances of any premises or facilities that do not comply with the rules. Primitive camp and picnic grounds offered by this state or a political subdivision of this state are exempt from rules adopted pursuant to this paragraph but are subject to approval by a county health department under sanitary regulations adopted pursuant to section 36-183.02. Rules adopted pursuant to this paragraph do not apply to two or fewer recreational vehicles as defined in section 33-2102 that are not park models or park trailers, that are parked on owner-occupied residential property for less than sixty days and for which no rent or other compensation is paid. For the purposes of this paragraph, “primitive camp and picnic grounds” means camp and picnic grounds that are remote in nature and without accessibility to public infrastructure such as water, electricity and sewer.

9. Define and prescribe reasonably necessary measures concerning the sewage and excreta disposal, garbage and trash collection, storage and disposal, water supply and food preparation of all public schools. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained in any public school and shall provide for inspection of these premises and facilities and for abatement as public nuisances of any premises that do not comply with the minimum standards.

10. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious health conditions at these places. The rules shall prescribe minimum standards for sanitary conditions that shall be maintained at any public or semipublic swimming pool or bathing place and shall provide for inspection of these premises and for abatement as public nuisances of any premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of environmental quality and shall be consistent with the rules adopted by the director of the department of environmental quality pursuant to section 49-104, subsection B, paragraph 12.

11. Prescribe reasonably necessary measures to keep confidential information relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects and associates of communicable disease patients. In no event shall confidential information be made available for political or commercial purposes.

12. Prescribe reasonably necessary measures regarding human immunodeficiency virus testing as a means to control the transmission of that virus, including the designation of anonymous test sites as dictated by current epidemiologic and scientific evidence.

13. Establish an online registry of food preparers that are authorized to prepare cottage food products for commercial purposes pursuant to paragraph 4 of this subsection. A registered food preparer shall renew the registration every three years and shall provide to the department updated registration information within thirty days after any change.

14. Prescribe an exclusion for fetal demise cases from the standardized survey known as “the hospital consumer assessment of healthcare providers and systems”.

J. The rules adopted under the authority conferred by this section shall be observed throughout the state and shall be enforced by each local board of health or public health services district, but this section does not limit the right of any local board of health or county board of supervisors to adopt ordinances and rules as authorized by law within its jurisdiction, provided that the ordinances and rules do not conflict with state law and are equal to or more restrictive than the rules of the director.
K. The powers and duties prescribed by this section do not apply in instances in which regulatory powers and duties relating to public health are vested by the legislature in any other state board, commission, agency or instrumentality, except that with regard to the regulation of meat and meat products, the department of health services and the Arizona department of agriculture within the area delegated to each shall adopt rules that are not in conflict.

L. The director, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section.

M. After consultation with the state superintendent of public instruction, the director shall prescribe the criteria the department shall use in deciding whether or not to notify a local school district that a pupil in the district has tested positive for the human immunodeficiency virus antibody. The director shall prescribe the procedure by which the department shall notify a school district if, pursuant to these criteria, the department determines that notification is warranted in a particular situation. This procedure shall include a requirement that before notification the department shall determine to its satisfaction that the district has an appropriate policy relating to nondiscrimination of the infected pupil and confidentiality of test results and that proper educational counseling has been or will be provided to staff and pupils.

N. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (f) of this section, food and drink are exempt from the rules prescribed in subsection I of this section if offered at locations that sell only commercially prepackaged food or drink that is not potentially hazardous, without a limitation on its display area.

O. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (h) of this section, a whole fruit or vegetable grown in a public school garden that is washed and cut on-site for immediate consumption is exempt from the rules prescribed in subsection I of this section.

P. Until the department adopts an exclusion by rule as required by subsection I, paragraph 14 of this section, the standardized survey known as "the hospital consumer assessment of healthcare providers and systems" may not include patients who experience a fetal demise.

Q. Until the department adopts exemptions by rule as required by subsection I, paragraph 4, subdivision (j) of this section, spirituous liquor and commercially prepackaged food, crackers or pretzels that meet the requirements of subsection I, paragraph 4, subdivision (j) of this section are exempt from the rules prescribed in subsection I of this section.

R. For the purposes of this section:
   1. "Cottage food product":
      (a) Means a food that is not potentially hazardous or a time or temperature control for safety food as defined by the department in rule and that is prepared in a home kitchen by an individual who is registered with the department.
      (b) Does not include foods that require refrigeration, perishable baked goods, salsas, sauces, fermented and pickled foods, meat, fish and shellfish products, beverages, acidified food products, nut butters or other reduced-oxygen packaged products.

   2. "Fetal demise" means a fetal death that occurs or is confirmed in a licensed hospital. Fetal demise does not include an abortion as defined in section 36-2151.

36-694. Report of blood tests; newborn screening program; committee; fee; definitions

A. When a birth or stillbirth is reported, the attending physician or other person required to report the birth shall state on the certificate whether a blood test for syphilis was made on a specimen of blood taken from the woman who bore the child or from the umbilical cord at delivery, as required by section 36-693, and the approximate date when the specimen was taken.

B. When a birth is reported, the attending physician or person who is required to report the birth shall order or cause to be ordered tests for certain congenital disorders, including hearing disorders. The results of tests for these disorders must be reported to the department of health services. The department of health services shall specify in rule the disorders, the process for collecting and submitting specimens and the reporting requirements for test results.
C. When a hearing test is performed on a newborn, the initial hearing test results and any subsequent hearing test results must be reported to the department of health services as prescribed by department rules.

D. The director of the department of health services shall establish a newborn screening program within the department to ensure that the testing for congenital disorders and the reporting of hearing test results required by this section are conducted in an effective and efficient manner. The newborn screening program shall include all congenital disorders that are included on the recommended uniform screening panel adopted by the secretary of the United States department of health and human services for both core and secondary conditions. Beginning January 1, 2022, disorders that are added to the core and secondary conditions list of the recommended uniform screening panel shall be added to this state's newborn screening panel within two years after their addition to the recommended uniform screening panel. The newborn screening program shall include an education program for the general public, the medical community, parents and professional groups. The director shall designate the state laboratory as the only testing facility for the program, except that the director may designate other laboratory testing facilities for conditions or tests added to the newborn screening program on or after July 24, 2014. If the director designates another laboratory testing facility for any condition or test, the director shall require the facility to follow all of the privacy and sample destruction time frames that are required of the state laboratory.

E. The newborn screening program shall establish and maintain a central database of newborns and infants who are tested for hearing loss and congenital disorders that includes information required in rule. Test results are confidential subject to the disclosure provisions of sections 12-2801 and 12-2802.

F. If tests conducted pursuant to this section indicate that a newborn or infant may have a hearing loss or a congenital disorder, the screening program shall provide follow-up services to encourage the child's family to access evaluation services, specialty care and early intervention services.

G. The director shall establish a committee to provide recommendations and advice to the department on at least an annual basis regarding newborn screening best practices and emerging trends.

H. The director may establish by rule a fee that the department may collect for operating the newborn screening program, including contracting for the testing pursuant to this section. The director shall present any change to the fee for the newborn screening program to the joint legislative budget committee for review.

I. Not later than sixty days after the department adjusts the newborn screening program fee established pursuant to subsection H of this section:
   1. Each health insurer that is subject to title 20 shall update its hospital rates that include newborn screening to reflect the increase.
   2. For the Arizona health care cost containment system and contractors acting pursuant to chapter 29, article 1 of this title that are not subject to title 20, the Arizona health care cost containment system shall update its hospital rates that include newborn screening to reflect the increase.

J. For the purposes of this section:
   1. "Infant" means a child who is twenty-nine days of age to two years of age.
   2. "Newborn" means a child who is not more than twenty-eight days of age.
DEPARTMENT OF HEALTH SERVICES
Title 9, Chapter 16, Article 8

New Article: Article 8


New Table: Table 8.1
MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 11, 2022

SUBJECT: Department of Health Services
Title 9, Chapter 16, Article 8

New Article: Article 8


New Table: Table 8.1

New Section: R9-16-809, R9-16-810

Summary:

This regular rulemaking from the Department of Health Services relates to rules in Title 9, Chapter 16, Article 8 regarding Community Health Workers. In this regular rulemaking the Department seeks to promulgate new rules in Title 9, Chapter 16, Article 8 for Certification of Community Health Workers established by Laws 2018, Chapter 300. The Department plans to promulgate rules in accordance with A.R.S. §§ Title 41, Chapter 6, that are necessary for the proper administration and enforcement to prescribe the scope of practice and the core competencies of certified community health workers; describe and define reasonable and necessary minimum qualifications for certified community health workers; establish standards
and requirements for the establishment of certified community health worker’s education and training programs; adopt standards and requirements for the approval or acceptance of continuing education courses and programs for the renewal of a certificate; establish minimum education, training, experience and other qualifications that a certified community health worker must possess to qualify as a trainer in any education, training or continuing education program for certified community health workers; establish the criteria for granting, denying, suspending, and revoking a certificate; and establish and collect nonrefundable fees for certification as a community health worker.

The Department received an exception from the rulemaking moratorium established by Executive Order 2019-01 on October 4, 2019 and final approval to submit to the Council on July 11, 2022.

1. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   Yes, the Department cites to both general and specific statutory authority.

2. **Do the rules establish a new fee or contain a fee increase?**

   Yes, the rules establish new fees pursuant to A.R.S. §§ 36-765.01 and 36-765.05.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   The Department did not review or rely on any study for this rulemaking.

4. **Summary of the agency’s economic impact analysis:**

   The Department anticipates that it will most likely incur a moderate cost for promulgating new rules as well as cost related to allocation of administrative staff to oversee the applications and renewals for individuals who wish to obtain or renew a community health worker (CHW) certification. The Department anticipates that it will most likely receive a significant benefit for having rules that deliver and increase the delivery of community health services in communities in need.

   The Department expects health care facilities and health care providers will most likely not incur any costs related to the rules for the certification of CHWs and rather will receive a significant benefit for having access to individuals who have been certified by the Department and whose education, work experience, and services hours completed have been verified.

   The Department expects applicants wishing to be a certified CHW and certified CHWs seeking renewal will incur a moderate cost for paying an initial application fee of $100,
initial certification fee if $200, and every two years, a renewal fee of $200. The Department believes these fees are consistent with other fees related to similar certifications, such as midwives and some radiation technologists. The Department also anticipates applicants and CHWs will most likely receive a significant benefit for having rules that provides a form of credential when seeking employment as a CHW or volunteer. The Department expects communities of the general public will not incur any cost for having new rules that provide verification and certification of individual who will intercede on their behalf when community health services are needed and may even be an individual’s only access to care.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

The Department has determined that the benefits outweigh potential costs associated with this rulemaking, and that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking.

6. **What are the economic impacts on stakeholders?**

The Department identifies affected persons as the Department, health care facilities, health care providers, applicants seeking certification as a community health worker (CHW), and communities of the general public where community health services are provided.

The Department anticipates that the cost associated with the rulemaking to be moderate for a rule analyst and program staff to draft new rules in Chapter 16, Article 8 and to communicate with stakeholders to ensure that the Department is aware of concerns stakeholders may have, and, as appropriate, change the draft rules. The Department also expects that the benefit of having the rules will be significant and responsive to the public’s call for providing certification of CHWs. Additionally, the Department anticipates that the Department will incur moderate costs to establish a program with staff that will process, review, and approve applications and issue certifications, as specified in the new rules. Further, the Department expects to incur additional substantial costs for office equipment, development of a computer database for applicants and certified CHWs, creating a CHWs webpage, including updates and maintenance for the two, and other miscellaneous costs for security, utilities, insurances, and the like. The Department expects a significant benefit may occur for having a CHW Certification Program that ensures CHWs may certify/confirm their skills and proficiencies to provide community health services to clients in Arizona communities.

The CHWs rules are expected to increase benefits for businesses by not only increasing the quality of care provided to clients, but also by increasing the number of clients receiving care. The Department anticipates that businesses may be more likely to hire CHWs to provide health and community services if a CHW provides a credential that is
issued by the Department and demonstrates the CHW’s specific skills, knowledge, and experience related to clients’ care.

The Department expects that certified CHWs who wish to provide trainings and instructions will receive a significant benefit for having rules that clarify the requirements for practicing as a certified CHW trainer. The rules may also provide a significant benefit to certified CHWs who wish to provide trainings and supervision to individuals who wish to obtain CHW certification. CHWs who currently provide trainings and supervision and complete the requirements for certification may incur a minimal cost for having more individuals attending their trainings after the certified CHW obtains a CHW trainer certification. Certified CHW trainers who experience an increase in trainings attendance will most likely also experience a significant increase in income. The Department expects the minimal cost for having more individuals attending trainings will be less than the fees collected for having more attending trainings. Increasing employed certified CHWs’ skills and knowledge will likely increase the types of community health services provided to clients and may increase the number of clients receiving better quality and a greater variety of community health services which is the best outcome for Arizonans.

The Department anticipates individuals who wish to obtain a CHW certification will receive a significant benefit for rules that establish a CHW certification program and CHW certification is anticipated to increase opportunities for employment and amount of wages a CHW may receive. The Department expects the application process may cause a minimal cost for applicants. However, the Department also expects that the minimal cost for submitting an application will be decreased by an applicant applying online and from an applicant’s location rather than traveling to the Department of Health Services. Applicants may receive a significant benefit for having rules that provide eligibility requirements that in addition to accepting public education and experience, also accept paid or volunteer experience equal to or greater than 960 hours without having public education or trainings. The Department expects the benefit of completing the required continuing education course will be greater than the fees.

The Department believes that clients and the public will receive a significant benefit for having rules that support increasing the number of CHWs in the state and ensures greater protection to the public health and safety for all Arizonans.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

The Department made changes to R9-16-801, definitions (4), (26), and (27) to clarify behavioral health services, physical health services, and service provider practices specified in statutes. Council staff does not find the changes to be a substantial change, considered as a whole, from the proposed rules.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**
The Department indicates they received comments from Partners in Health in the United States, and the Arizona Advisory Council on Indian Health Care, in support of the proposed rules, and further encouraged the Department to integrate Community Health Workers into interdisciplinary teams.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

The Department indicates the rules do not require the issuance of a general permit. A.R.S. § 36-765.01 requires the Department to issue a community health worker certificate to persons who meet the qualifications prescribed in statutes and in rules adopted by the Department. Additionally, A.R.S. § 36-765.03 provides the Department authority to deny, revoke, or suspend an applicant or community health worker’s certification.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

Not applicable. There are no corresponding federal laws.

11. **Conclusion**

As mentioned above, in this regular rulemaking the Department seeks to promulgate new rules in Title 9, Chapter 16, Article 8 for Certification of Community Health Workers established by Laws 2018, Chapter 300. The Department is seeking a regular 60-day delayed effective date for these rules.

Council staff recommends approval of this regular rulemaking.
August 19, 2022

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Department of Health Services, 9 A.A.C. 16, Article 8, Regular Rulemaking – Amended Cover Letter

Dear Ms. Sornsin:

1. The close of record date: May 18, 2022

2. Whether the rulemaking relates to five-year-review report and, if applicable, the date the report was approved by the Council:
   The rulemaking for 9 A.A.C. 16, Article 8 does not relate to a five-year-review report.

3. Whether the rulemaking establishes a new fee and, if so, the statutes authorizing the fee:
   The rulemaking does establish a new fee pursuant to A.R.S. §§ 36-765.01 and 36-765.05.

4. Whether the rulemaking contains a fee increase:
   The rulemaking does not contain a fee increase.

5. Whether an immediate effective date is requested pursuant to A.R.S. § 41-1032:
   The Department is requesting the normal 60-day delayed effective date for this rulemaking.

The Department certifies that the Preamble of this rulemaking discloses a reference to any study relevant to the rule that the Department reviewed and either did or did not rely on its evaluation of or justification for the rule.

The Department certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.

The following documents are enclosed:

Douglas A. Ducey | Governor  Don Herrington | Interim Director

150 North 18th Avenue, Suite 500, Phoenix, AZ 85007-3247  P | 602-542-1025  F | 602-542-1062  W | azhealth.gov  
Health and Wellness for all Arizonans
1. Notice of Final Rulemaking, including the Preamble, Table of Contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;
3. General and specific statutes authorizing the rules, including relevant statutory definitions;
4. Written comments; and
5. Governor’s exception to moratorium and approval to submit to GRRC.

The Department’s point of contact for questions about the rulemaking documents is Emily Carey at Emily.Carey@azdhs.gov.

Sincerely,

[Signature]

Stephanie Elzenga
Director’s Designee

RL: tk

Enclosures
NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 16. DEPARTMENT OF HEALTH SERVICES – OCCUPATIONAL LICENSING
ARTICLE 8. COMMUNITY HEALTH WORKERS

PREAMBLE

1. Articles, Part, and Sections Affected (as applicable) | Rulemaking Action
--- | ---
Article 8 | New Article
R9-16-801 | New Section
R9-16-802 | New Section
R9-16-803 | New Section
R9-16-804 | New Section
R9-16-805 | New Section
R9-16-806 | New Section
R9-16-807 | New Section
R9-16-808 | New Section
Table 8.1 | New Table
R9-16-809 | New Section
R9-16-810 | New Section

2. Citations to the agency’s statutory rulemaking authority to include authorizing statutes (general) and the implementing statutes (specific):
Authorizing statute: A.R.S. §§ 36-104(3) and 36-136(G)
Implementing statutes: A.R.S. §§ 765.01, 36-765.02, and 36-765.05

3. The effective date of the rule:
The Arizona Department of Health Services (Department) requests the normal 60-day delayed effective date for this rulemaking.

4. 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 Proposed Rulemaking: 28 A.A.R. 765, April 15, 2022
Notice of Rulemaking Docket Opening: 28 A.A.R. 663, March 25, 2022
Notice of Rulemaking Docket Opening: 27 A.A.R. 725, May 7, 2021
Notice of Rulemaking Docket Opening: 26 A.A.R. 626, April 3, 2020

5. The agency's contact person who can answer questions about the rulemaking:
6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Pursuant to the rulemaking moratorium established by Executive Order 2019-01, the Arizona Department of Health Services (“Department”) received an exception approval from the moratorium to promulgate new rules at Title 9, A.A.C. 16, Article 8 for certification of community health workers established by Laws 2018, Chapter 300. The Department plans to promulgate rules in accordance with A.R.S. Title 41, Chapter 6, Articles 3 and 10 that are necessary for the proper administration and enforcement to prescribe the scope of practice and the core competencies of certified community health workers; describe and define reasonable and necessary minimum qualifications for certified community health workers; establish standards and requirements for the establishment of certified community health worker’s education and training programs; adopt standards and requirements for the approval or acceptance of continuing education courses and programs for the renewal of a certificate; establish minimum education, training, experience and other qualifications that a certified community health worker must possess to qualify as a trainer in any education, training or continuing education program for certified community health workers; establish the criteria for granting, denying, suspending, and revoking a certificate; and establish and collect nonrefundable fees for certification as a
community health worker. The Department cites A.R.S. §§ 36-765.02, 36-765.03, 36-765.05 as specific authority for the Department to establish voluntary certification of community health workers and to establish rules that regulate administration and enforcement, including authority to deny, suspend or revoke a certification permanently or for a fixed period of time. The Department will promulgate rules in 9 A.A.C. 16, Article 8 through a regular rulemaking according to A.R.S. Title 41, Chapter 6.

7. **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 Department did not review or rely on any study for this rulemaking.

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

   Not applicable

9. **The summary of the economic, small business, and consumer impact:**

   As used in the 2022 Economic, Small Business, and Consumer Impact Statement, annual costs and benefits associated with the 9 A.A.C. 16, Article 8 rulemaking are designated as minimal when more than $0 and less than $1,000, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater. A cost or benefit is indicated as significant when meaningful or important and not readily subject to quantification. No new FTEs are required due to this rulemaking. The Department identifies affected persons as the Department, health care facilities, health care providers, applicants seeking certification as community health worker, and communities of the general public where community health services are provided. The Department anticipates that it will most likely incur a moderate cost for promulgating new rules as well as cost related to allocation of administrative staff to oversee the applications and renewals for individuals who wish to obtain or renew a community health worker certification. The Department anticipates that it will most likely receive a significant benefit for having rules that delivers and increases the delivery of community health services in communities in need. The Department expects health care facilities and health care providers will most likely not incur any costs related to the rules for the certification of community health workers and rather will receive a significant benefit for having access to individuals who have been certified by the Department and whose education, work experience, and services hours completed have been verified. Health care facilities and health care providers may also benefit from having more
individuals available who choose to work in neighborhood communities and focus on providing community health services to individuals who are unable or do not have easy access to medical care. The Department expects applicants wishing to be a certified community health worker and certified community health workers seeking renewal will incur a moderate cost for paying an initial application fee of $100, initial certification fee of $200, and every two years, a renewal fee of $200. The Department believes these fees are consistent with other fees related to similar certifications, such as midwives and some radiation technologists. The Department also anticipates applicants and certified community health workers will most likely receive a significant benefit for having rules that provides a form of credential when seeking employment as a community health worker or volunteer. The Department expects communities of the general public will not incur any cost for having new rules that provide verification and certification of individual who will intercede on their behalf when community health services are needed and may even be an individuals only access to care. The Department has determined that the benefits outweigh potential costs associated with this rulemaking.

10. **A description of any changes between the proposed rulemaking, including supplemental notices, and the final rulemaking:**

The Department made changes in R9-16-801, definitions (4), (26), and (27) to clarify behavioral health services, physical health services, and service provider practices specified in statutes. The Department believes the changes are non-substantive and increase the rules clarity and understandability. Changes are:

4. “Behavioral health services” means information and care provided by certified or licensed behavioral health professionals in accordance with A.R.S. Title 32, Chapter 32 and consistent with practices specified in A.R.S. § 32-3251(8).

26. “Physical health services” means information and care provided by licensed health professionals as defined in accordance with practices specified in A.R.S. § 32-3201.

27. “Service provider” means a person, who provides behavioral health services or physical health services in accordance with health professionals specified in A.R.S. § 32-3201, and behavioral health professionals specified in A.R.S. § 32-3251(8) who provide services to clients according to a contract or service agreement.

11. **Agency's summary of the public or stakeholder comments or objections made about the rulemaking and the agency response to the comments:**

The Department received comments from Partners in Health in the United States (Partners in Health) and Arizona Advisory Council on Indian Health Care (Arizona Advisory Council). Partners in Health is a non-profit, social justice organization based in Boston, Massachusetts. The
Department found the comments received supported Arizona promulgating CHWs rules and encouraged the Department to integrate CHWs into interdisciplinary teams. The Department appreciates Partners in Health comments and elected not to respond to Partners in Health’s offer to share their materials. The Department also received a written comment by e-mail from a representative with the Arizona Advisory Council who attended the oral proceeding. The Arizona Advisory Council is established in A.R.S. § 36-2902.01 to give tribal governments, tribal organizations, and urban Indian health care organizations in the state representation in shaping Medicaid and health care policies and laws that impact the population they serve. The comment was received by the Department after the oral proceeding had ended and clarified that “After review of the draft rules, we [Arizona Advisory Council] realize that our concerns have been addressed. We will not be submitting any written comments.”

12. 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:
There are no other matters prescribed by statutes applicable specifically to the Department or this specific rulemaking.

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:
A.R.S. § 36-765.01 requires the Department to issue a community health worker certificate to persons who meets the qualifications prescribe in statutes and in rules adopted by the Department. Additionally, A.R.S. § 36-765.03 provides the Department authority to deny, revoke, or suspend an applicant or community health worker’s certification. For this reason, the Department does not use a general permit. The Department believes that under A.R.S. § 41-1037(A)(2) and (3) that a general permit is not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:
There are no federal rules applicable to the subject of the rule.

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 business competitiveness analysis was submitted to the Department.

13. Incorporated by reference and their location in the rules:
14. **Whether the rule was previously made, amended, or repealed as an emergency rules. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:**

The rule was not previously made as an emergency rule.

15. **The full text of the rules follows:**
Section

R9-16-801. Definitions
R9-16-802. CHW Eligibility and Scope of Practice
R9-16-803. CHW Trainer Qualifications
R9-16-804. Initial CHW Application
R9-16-805. Certification Renewal
R9-16-806. Continuing Education
R9-16-807. Enforcement
R9-16-808. Time-frames

Table 8.1 Time-frames (in calendar days)

R9-16-809. Changes Affecting a Certificate; Request for a Duplicate Certificate
R9-16-810. Fees
ARTICLE 8. COMMUNITY HEALTH WORKERS

R9-16-801. Definitions
In addition to the definitions in A.R.S. § 36-765, the following definitions apply in this Article, unless otherwise specified:

1. “Accredited” means approved by the:
   a. New England Commission of Higher Education,
   b. Middle States Commission on Higher Education,
   c. Higher Learning Commission,
   d. Northwest Commission on Colleges and Universities,
   e. Southern Association of Colleges and Schools Commission on Colleges, or
   f. WASC Senior College and University Commission.

2. “Administrative completeness review time-frame” has the same meaning as in A.R.S. § 41-1072.

3. “Applicant” means an individual who submits an application and required documentation for approval to practice as a certified CHW.

4. “Behavioral health services” means information and care provided by certified or licensed behavioral health professionals consistent with practices specified in A.R.S. § 32-3251(8).

5. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run and including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

6. “Certification” means an approval granted to individuals who meet the qualifications, including education and training requirements, in this Article for certified CHWs.

7. “Certified CHW” means the same as a “certified community health worker” in A.R.S. § 36-765.

8. “CHW” means the same as a “community health worker” in A.R.S. § 36-765.

9. “CHW trainer” means an individual who meets the requirements in R9-16-803 and provides training and supervision to individuals who seek certification as a certified CHW.

10. “CHW training program” means approved community health education and instruction required for individuals seeking a CHW certification issued by the Department.
11. “Client” means an individual receiving community health services provided by a certified CHW.

12. “Community Health Representative” or “CHR” means an individual who has completed an Indian Health Services National Training Program for:
   a. Basic training through completing general health education to promote health and social services and assist in the prevention of disease and disabilities in tribal communities; or
   b. Advanced training through increased health and knowledge for a variety of public health topics designed to improve outreach capacity to advance tribal health systems.

13. “Community health services” means non-medical support, care, and assistance:
   a. Specified in the scope of practice and core competencies in this Article;
   b. Provided by a certified CHW to a client on behalf of a service provider, whether physical health services or behavioral health services; and
   c. Improves the quality of delivery and coordination of care resulting in better medical and behavioral health outcomes.

14. “Continuing education” means a course that provides training and instruction that is designed to develop or improve a certified CHW’s or certified CHW trainer’s professional competence in areas directly related to the practice of a CHW.

15. “Contractor” means the same as in A.R.S. § 36-2901.

16. “Core competencies” means curriculum that provides knowledge to develop core skills and assume job responsibilities, including:
   a. Communication skills,
   b. Interpersonal and relationship-building,
   c. Service coordination and navigation,
   d. Capacity-building,
   e. Advocacy,
   f. Education and facilitation,
   g. Individual and community assessment,
   h. Outreach,
   i. Professional skills and conduct,
   j. Evaluation and research skills, and
   k. Knowledge base.

17. “Course” means a workshop, seminar, lecture, conference, or class.
18. “Direct services” means personal interaction to assist or deliver care provided by a certified CHW, including:
   a. Transportation assistance,
   b. Fall risk assessments,
   c. Welfare checks,
   d. Employment assistance, and
   e. Other similar health and social services not provided by a licensed health or behavioral health professional.

19. “Documentation” means information in written, photographic, electronic or other permanent form.


21. “National Training Program” means a health education and skills management curriculum approved by Indian Health Services for individuals wishing to obtain a CHR certification to provide community health services in a tribal and Native community.

22. “Observation” means to witness:
   a. The provision of community health services to a client, or
   b. A demonstration of how to provide community health services to a client.


24. “Overall time-frame” has the same meaning as in A.R.S. § 41-1072.

25. “Person” means the same as in A.R.S. § 1-215 and includes a governmental agency.

26. “Physical health services” means information and care provided by licensed health professionals consistent with practices specified in A.R.S. § 32-3201.

27. “Service provider” means a person, who engages in practice of health professionals specified in A.R.S. § 32-320, and behavioral health professionals specified in A.R.S. § 32-3251(8) who provide services to clients according to a contract or service agreement.

28. “Supervision” means training and monitoring provided by a certified CHW trainer specified in A.R.S. § 36-765.02(A)(5) to prepare individuals wishing to obtain a CHW certification.

29. “Training and instruction” means educational activities that develop and improve an individual’s professional competence in areas related to the practice as a certified CHW specified in A.R.S. § 36-765 and specific to the delivery of services identified in CHW’s scope of practice and core competencies specified in this Article.
R9-16-802. Community Health Workers Eligibility and Scope of Practice

A. An individual may provide community health services in Arizona without obtaining certification as a certified CHW specified in this Article.

B. An individual is eligible to practice as a certified CHW, if the individual:
   1. Is 18 years of age or older;
   2. Has at least a high school diploma or high school equivalency diploma;
   3. Has documentation of:
      a. Nine hundred and sixty hours of paid or volunteer experience providing CHR or CHW services in the core competencies specified in this Article and completed during the previous three-year time-period:
         i. In a licensed health care facility;
         ii. In the service of a licensed health care provider specified in A.R.S. § 32-3201(2), including licensed behavioral health care providers specified in A.R.S. § 32-3251(8); or
         iii. In the service of a contractor providing CHR or CHW services under A.R.S. Title 36, Chapter 29, Article 1 specified in A.R.S. § 36-765.02(C);
      b. Completing a CHW certificate program, including core competencies, provided by an accredited college, and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years;
      c. Completing a CHW training program provided by an organization or certified CHW trainer, including core competencies and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years; or
      d. Completing a CHR National Training Program for:
         i. Basic training certification and 480 hours of paid or volunteer CHR or CHW experience completed during the previous three years; or
         ii. Advanced training certification and 380 hours of paid or volunteer CHR or CHW experience completed during the previous three years; and
   4. Completes an initial CHW application.

C. A certified CHW’s scope of practice includes:
   1. Providing cultural mediation among individuals, communities, and health and social systems;
   2. Providing culturally appropriate health education and information;
   3. Providing care coordination, case coordination and system navigation;
4. Providing coaching and social support;
5. Advocating for individuals and communities;
6. Building individual and community capacity;
7. Providing direct services;
8. Implementing individual and community assessments;
9. Conducting outreach; and
10. Participating in evaluation and research.

D. In addition to core competencies specified in R9-16-801(16), a CHW’s roles and activities may include:

1. Diabetes education;
2. Disease intervention;
3. Nutrition, specifically food preparation and purchasing;
4. Parenting education;
5. Community wellness partner;
6. Connect clients to health education and community resources;
7. Blood pressure education;
8. Delivery of medical supplies and equipment to assist client’s needs;
9. Outreach to clients who are out of care;
10. Hearing and vision screenings; and
11. Other similar health and social services provided on behalf of a health and behavioral health service providers.

E. A certified CHW shall not provide physical health services or behavioral health services to a client.

R9-16-803. Community Health Workers Trainer Qualifications

A. A certified CHW, who wishes to provide training and supervision to individuals who wish to obtain a CHW certification, shall:

1. Be 21 years of age or older;
2. Have at least:
   a. A high school diploma or high school equivalency diploma and 250 hours providing training and instruction related to practices specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification;
   b. A diploma in public health or other medical disciplines, including behavioral health, from an accredited college or university for which the individual received a degree, and 150 hours of providing training and instruction related to practices
specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification; or

c. A diploma in public health or other medical disciplines, including behavioral health, from an accredited college or university for which the individual received a degree and provided training and instruction related to practices specified in R9-16-802(C) and (D) to individuals who wish to obtain a CHW certification including:
   i. An associate’s degree and 200 hours providing training and instruction;
   ii. A bachelor’s degree and 150 hours providing training and instruction;
   iii. A master’s degree and 100 hours providing training and instruction; or
   iv. A doctorate’s degree and 50 hours providing training and instruction;

3. Maintain documentation that demonstrates completion of the requirements in subsection (A)(2); and

4. Provide copy of documentation specified in subsection (A)(3) to individuals who wish to obtain a CHW certification for individuals to provide to the Department when completing an initial CHW application.

B. A certified CHW trainer who provides training and supervision to an individual seeking certification as a certified CHW shall:

1. Establish a record for each individual who receives training and supervision that includes:
   a. The individual’s name, home address, telephone number, and e-mail address;
   b. A plan indicating the types of skills and number of hours allocated to the development of each skill that is expected to be completed;
   c. A document listing each occurrence of training and supervision provided to an individual that includes:
      i. Business name and address where training or supervision occurred,
      ii. The date and time when a training or supervision started and ended,
      iii. The types of knowledge and skills provided, and
      iv. Notation explaining the individual’s progress;
   d. Documentation of evaluations provided to the individual during the time training or supervision was provided; and
   e. Documentation of when training and supervision was terminated.

2. Maintain an individual’s CHW records for at least two years after the last date the individual received training and supervision from the certified CHW trainer.
3. Provide individuals, who have completed training and supervision, a certificate that specifies:
   a. The individual’s first and last name;
   b. The title of the training;
   c. A description of the knowledge or types of skills provided;
   d. The core competencies covered;
   e. The number of classroom training hours attended;
   f. The number of supervision hours provided, if applicable;
   g. The individual’s training score, whether pass or not pass;
   h. The date the training was held or completed;
   i. The name of the organization providing training and location; and
   j. The CHW trainer’s written name, signature, and date signed.

R9-16-804. Initial Community Health Workers Application

A. An applicant for a CHW certification shall submit to the Department:
   1. An application provided in a Department-provided format that contains:
      a. The applicant's name, home address, telephone number, and e-mail address;
      b. The applicant’s Social Security number, as required under A.R.S. §§ 25-320 and
         25-502;
      c. Whether the applicant has completed high school or a high school equivalency
         program;
      d. Whether the applicant is or has been certified as a CHW in another state or
         country;
      e. Whether the applicant has ever been convicted of a felony or a misdemeanor
         involving moral turpitude in this or another state;
      f. If the applicant has been convicted of a felony or a misdemeanor involving moral
         turpitude:
         i. The date of the conviction,
         ii. The state or jurisdiction of the conviction,
         iii. An explanation of the crime of which the applicant was convicted, and
         iv. The disposition of the case;
      g. Whether the applicant has had a certification or license revoked or suspended by
         any state within the previous two years;
      h. Whether the applicant is currently ineligible for certification or licensure in any
         state because of a revocation or suspension;
i. Whether any disciplinary action has been imposed by any state, territory or district in this country for an act related to the applicant’s practice as a CHW;

j. Whether the applicant agrees to allow the Department to submit supplemental requests for information under A.R.S. § 41-1075;

k. An attestation that the information submitted is true and accurate; and

l. The applicant’s signature and date of signature;

2. If applicable, a list of all states and countries in which the applicant is or has been certified or licensed as a CHW;

3. Documentation of an applicant’s conviction of a felony or a misdemeanor involving moral turpitude in this or another state that includes:
   a. The date of the conviction,
   b. The state or jurisdiction of the conviction,
   c. A description of the crime of which the applicant was convicted, and
   d. The disposition of the case;

4. If a certificate or license for the applicant has been revoked or suspended by any state within the previous two years, documentation that includes:
   a. The date of the revocation or suspension,
   b. The state or jurisdiction of the revocation or suspension, and
   c. An explanation of the revocation or suspension;

5. If the applicant is currently ineligible for certificate or license in any state because of a revocation or suspension, documentation that includes:
   a. The date of the ineligibility for certification or license,
   b. The state or jurisdiction of the ineligibility for certification or license, and
   c. An explanation of the ineligibility for certification or license;

6. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant’s practice as a CHW, documentation that includes:
   a. The date of the disciplinary action,
   b. The state or jurisdiction of the disciplinary action,
   c. An explanation of the disciplinary action, and
   d. Any other applicable documents, including a legal order or settlement agreement;

7. Documentation of the applicant’s citizenship or alien status that complies with A.R.S. § 41-1080;

8. As applicable, documentation that demonstrates:
a. Nine hundred and sixty hour of paid or volunteer CHW experience in core competencies specified in R9-16-802(B)(3)(a):
   i. The applicant’s name;
   ii. As applicable, the name of each health care facility, licensed health care provider, or contractor for whom core competencies were completed;
   iii. Name of the applicant’s supervisor and supervisor’s title;
   iv. The types of core competencies completed for each health care facility, licensed health care provider, or contractor listed in subsection (ii);
   v. The dates or range of dates when the core competencies in subsection (iv) were completed;
   vi. The number of hours completed for the core competencies listed in subsection (v); and
   vii. The supervisor’s signature and date of signature;

b. Completion of a CHW certificate program provided by an accredited college and 480 hours of paid or volunteer CHW experience specified in R9-16-802(B)(3)(b);

c. Completion of a CHW training program provided by an organization or certified CHW trainer and 480 hours of paid or volunteer CHW experience specified in R9-16-802(B)(3)(c), including:
   i. The applicant’s name;
   ii. The name of the CHW training program attended;
   iii. The name of the organization providing the CHW training program;
   iv. The types of core competencies completed;
   v. The dates or range of dates when the core competencies in subsection (iii) were completed;
   vi. The number of hours completed for each core competency completed in subsection (iv); and
   vii. The signature of the individual overseeing the instruction of the CHW training program and the date of signature;

d. Completion of a CHR National Training Program specific in R9-16-802(B)(3)(d):
   i. Basic training certification and 480 hours of paid or volunteer CHR or CHW experience; or
   ii. Advanced training certification and 380 hours of paid or volunteer CHR or CHW experience; and
Completion of high school or high school equivalency or higher degree; and


B. In lieu of the documentation required in (A)(8), an applicant may submit documentation to the Department that includes:

1. The name of each state that issued the applicant a current certification, including:
   a. The certification number of each current certification, and
   b. The date each current certification was issued;

2. Documentation of the professional certificate or license issued to the applicant by each state in which the applicant holds a professional certificate or license;

3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been certified or licensed in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
   b. Has met minimum education requirements specified in this Article;
   c. Has not voluntarily surrendered a certification or license in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.

C. The Department shall review the application and required documentation for certification as a CHW according to R9-16-808 and Table 8.1.

R9-16-805. Certification Renewal

A. From the date of issuance, a CHW certification is valid for two years.

B. At least 30 calendar days before the expiration date of a certification, an applicant shall submit to the Department:

1. A renewal application in a Department-provided format that contains:
   a. The applicant’s name, home address, telephone number, and e-mail address;
   b. The applicant’s certification number and date of expiration;
   c. Since the previous certification application, whether the applicant has been convicted of a felony or a misdemeanor involving moral turpitude in this or another state;
   d. If the applicant was convicted of a felony or a misdemeanor involving moral turpitude:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction.
iii. An explanation of the crime of which the applicant was convicted, and

iv. The disposition of the case;

e. Whether the applicant has had, within two years before the renewal application date, a certificate suspended or revoked by any state;

f. An attestation that:

i. The applicant has completed 24 hours of continuing education required in R9-16-806 and documentation of the completed continuing education is available upon the Department’s request;

ii. The applicant authorizes the Department to verify all information provided in the renewal application packet;

iii. The information submitted as part of the renewal application packet is true and accurate; and

iv. The applicant’s signature and date of signature.

2. A fee specified in R9-16-810.

C. Documentation of an applicant’s conviction of a felony or a misdemeanor involving moral turpitude in this or another state that includes the information specified in subsection (A)(1)(d) issued by the prosecuting state or jurisdiction.

D. An applicant who does not submit the documentation and the fee in subsection (B) shall apply for a new certificate in R9-16-804.

E. The Department shall review the application and required documentation for renewal certification as a CHW according to R9-16-808 and Table 8.1.

R9-16-806. Continuing Education

A. A certified CHW shall complete 24 hours of continuing education hours within the two years prior to renewing certification specified in A.R.S. § 36-765.02.

B. Continuing education shall:

1. Directly relate to CHW core competencies including services, skills, and knowledge that:

a. Facilitates access to quality of care delivery and health outcomes for clients receiving services; and

b. Expands health and wellness in diverse communities to reduce health disparities;

2. Have educational objectives that exceed an introductory level of knowledge related to health and community services; and

3. Consist of courses related to core competencies, such as:

a. Health and social service systems;

b. Disease prevention to help manage health conditions;
c. Health promotion education;
d. Health literacy and cross-cultural communication;
e. Referrals and providing follow-up;
f. Individual support and coaching;
g. Outreach methods and strategies;
h. Client and community assessment;
i. Health education for behavior change;
j. Provide direct services;
k. Home visits to provide education, assessment, and social support; and
l. Support, advocacy, and health system navigation for clients.

C. A continuing education course developed, endorsed, or sponsored by one of the following that meets the requirements in subsection (B):

1. National Community Health Worker Training Center;
2. Arizona Community Health Workers Association;
3. Centers for Disease Control and Prevention: Training and Continuing Education;
4. Arizona Alliance for Community Health Centers;
5. National Commission for Health Education Credentialing;
6. American Diabetes Association;
7. Western Region Public Health Training Center;
8. Indian Health Service; and
9. Other certified CHW training programs approved by the Department.

R9-16-807. Enforcement

A. The Department may deny, suspend, or revoke a certificate holder's certification, permanently or for a fixed period of time specified in A.R.S. § 36-765.03 and this Article.

B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:

1. The type of violation,
2. The severity of the violation,
3. The danger to the public health and safety,
4. The number of violations,
5. The number of clients affected by the violations,
6. The degree of harm to the consumer,
7. A pattern of noncompliance, and
8. Any mitigating or aggravating circumstances.
C. A certificate holder may appeal an enforcement action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

D. If a certified CHW is employed by a tribe and appears to have violated this Article according to A.R.S. § 36-765.03(D), the tribal government having jurisdiction and following Tribal ordinances and policies shall:
   1. Review and determine whether the certified CHW has violated this Article; and
   2. Provide the Department with a written determination whether denied, suspended, or revoked, including specific penalties from disciplinary actions taken by the tribal government.

R9-16-808. Time-frames

A. For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the overall time-frame.
   1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
   2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.

B. For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the administrative completeness review time-frame.
   1. The administrative completeness review time-frame begins the date the Department receives an application required in this Article.
   2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
      a. If a certificate application is not complete, the notice of deficiencies listing each deficiency and the information or documentation needed to complete the application.
      b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
      c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.
3. If the Department issues a certificate during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.

C. For a certificate or approval issued by the Department under this Article, Table 8.1 specifies the substantive review time-frame, which begins on the date the Department sends a written notice of administrative completeness.

1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department approved or denied the application.

2. During the substantive review time-frame:
   a. The Department may make one comprehensive written request for additional information or documentation; and
   b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.

3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.

4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the certificate or approval.

D. An applicant who is denied a certification may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Table 8.1. Time-frames (in calendar days)

<table>
<thead>
<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-frame</th>
<th>Administrative Completeness Review Time-frame</th>
<th>Time to Respond to Deficiency Notice</th>
<th>Substantive Review Time-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Application</td>
<td>A.R.S. § 36-765.01</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Certification Renewal</td>
<td>A.R.S. § 36-765.01</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

R9-16-809. Changes Affecting a Certificate; Request for a Duplicate Certificate
A. A certified CHW shall submit to the Department a notice in a Department-provided format within 30 calendar days after the effective date of a change in:
1. The certified CHW’s home address, telephone number, or e-mail address, including the new home address, telephone number, or e-mail address; and
2. The certified CHW’s name, including a copy of one of the following with the certified CHW’s new name:
   a. Marriage certificate,
   b. Divorce decree, or
   c. Other legal document establishing the certified CHW’s new name.

B. A certificate holder may obtain a duplicate certificate by submitting to the Department a written request for a duplicate certificate in a Department-provided format that includes:
   1. The certified CHW’s name and address,
   2. The certified CHW’s certification number and expiration date,
   3. The certified CHW’s signature and date of signature, and
   4. A duplicate certificate fee specified in R9-16-810.

R9-16-810. Fees
A. An applicant shall submit to the Department for a CHW certification, a $100 nonrefundable initial application fee.
B. An applicant shall submit to the Department for a CHW certification, a $200 initial certification fee.
C. A certified CHW shall submit to the Department for a renewal certification, a $200 nonrefundable renewal fee.
D. The fee for a duplicate certificate is $25.
E. An applicant for initial certification is not required to submit the applicable fee in subsections (A) and (B) if the applicant, as part of the applicable application in R9-16-804, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.
F. Subject to the availability of Department funding, an applicant may receive a discounted fee for an initial application, initial certification, or renewal certification.
ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

JUNE 2022

TITLE 9. HEALTH SERVICE

CHAPTER 16. DEPARTMENT OF HEALTH SERVICES – OCCUPATIONAL LICENSING

ARTICLE 8. COMMUNITY HEALTH WORKERS
1. **An identification of the rulemaking:**

Arizona Revised Statutes (A.R.S.) § 36-136(G) requires the Arizona Department of Health Services (Department) to “make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.” On May 16, 2018, House Bill (H.B.) 2324 was approved by the Governor and became effective August 3, 2018. H.B. 2324, Laws 2018, Ch. 300, establish a voluntary certification program for community health workers (CHWs) at A.R.S. §§ 36-765 through 36-765.07. The Governor, in a letter¹ to the Secretary of State, expressed “appreciation for legislation that forgoes mandatory licensing, and instead implements a voluntary certification.” The Governor further stated that “legislation recognizes the valuable service” provided by our health workers and without introducing overly burdensome licensing requirements. In accordance with the rulemaking moratorium established by Executive Order 2019-01, the Department received an exception approval to promulgate new rules at Arizona Administrative Code (A.A.C.) Title 9, Chapter 16, Article 8 for certification of CHWs. The Department plans to promulgate rules pursuant with A.R.S. Title 41, Chapter 6, Article 3. The new rules are necessary for the proper administration of the CHWs certification program and include requirements and standards that:

- Prescribe eligibility, scope of practice, and the core competencies of certified community health workers;
- Describe and define reasonable and necessary minimum qualifications for certified community health workers;
- Establish standards and requirements for the establishment of certified community health worker’s education and training programs;
- Adopt standards and requirements for the approval or acceptance of continuing education courses and programs for the renewal of a certificate;

¹ [Governor’s Letter, dated May 16, 2018](#)
• Establish minimum education, training, experience and other qualifications that a
certified community health worker must possess to qualify as a trainer in any education,
training, or continuing education program for certified community health workers;
• Establish the criteria for granting, denying, suspending, and revoking a certificate; and
• Establish and collect nonrefundable fees for certification as a community health worker.

The Department cites A.R.S. §§ 36-765.02, 36-765.03, and 36-765.05 as specific authority for the
Department to establish voluntary certification of CHWs and to establish rules to regulate
administration and enforcement, including authority to deny, suspend, or revoke a certification
permanently or for a fixed period of time. The Department plans to promulgate rules in 9 A.A.C.
16, Article 8 through a regular rulemaking according to A.R.S. Title 41, Chapter 6.

2. **An identification of the persons, who will be directly affected by, bears the costs of, or
directly benefits from the proposed rulemaking:**
   a. The Department,
   b. Persons who are service providers and employ certified CHWs,
   c. Persons who provide certified CHW trainings,
   d. Persons who wish to obtain a CHW certification, and
   e. Persons who are clients and the public.

3. **Cost/benefit analysis:** This analysis covers benefits and costs associated with the new rules for
certified CHWs defined in A.R.S.§ 36-765(1). No new full-time employees are required due to
this rulemaking. This rulemaking establishes licensing fees authorized by A.R.S.§ 36-765.052 and
fees collected are deposited in the health services licensing fund. The annual costs and benefits
are designated as minimal when less than $1,000, moderate when between $1,000 and $30,000
and substantial when greater than $30,000 or more. Costs and benefits are listed as significant
when meaningful or important, but not readily subject to quantification. The Department clarifies
the estimated costs and benefits identified in this Economic, Small Business, and Consumer
Impact Statement (EIS) related to the new requirements and standards in this rulemaking and
required by the statutory authority cited in Item 1. A description of affected persons and effects
are listed below.

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2 “The director, by rule, shall establish and collect nonrefundable fees for certification that are consistent with fees that are
prescribed pursuant to section 36-1908. The department shall deposit the fees in a segregated account in the health services
licensing fund established by section 36-414.”
<table>
<thead>
<tr>
<th>Description of Affected Groups</th>
<th>Description of Effect</th>
<th>Increased Cost/ Decreased Benefits</th>
<th>Decreased Cost/ Increased Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. State and Local Government Agencies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Department</td>
<td>Draft new rules for CHWs certification Establishes program to administer and issue certifications to persons who qualify as a community health worker Establishes CHW certification fees</td>
<td>Moderate Substantial None</td>
<td>Significant Significant</td>
</tr>
<tr>
<td><strong>B. Small Businesses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons who employ certified CHWs and provide support for certified-unpaid CHWs (volunteers)</td>
<td>Increase quality of care provided to clients Increase cost for CHW salaries</td>
<td>None Minimal</td>
<td>Significant</td>
</tr>
<tr>
<td>Persons who provide certified CHWs trainings</td>
<td>Provides CHW trainers’ qualifications and requirements for records and certification of CHWs Clarifies CHW trainings scope of practices and core competencies Increase in the number of persons attending CHW trainings</td>
<td>None None Minimal</td>
<td>Significant</td>
</tr>
<tr>
<td><strong>C. Consumers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons who wish to obtain a CHW certification</td>
<td>Apply for CHW certification and fee Provides CHW eligibility standards, scope of practice, core competencies Clarifies continuing education</td>
<td>Minimal None Minimal</td>
<td>Significant Significant</td>
</tr>
<tr>
<td>Persons who are clients and the public</td>
<td>Increase the quality and availability of community health services Increase in public health and safety</td>
<td>None None</td>
<td>Significant</td>
</tr>
</tbody>
</table>
The Department

A.R.S. §§ 36-765.01 through 36-765.06 provides authority to the Department to establish a Community Health Workers Program for individuals seeking a certificate of practice as a certified CHW. A.R.S. § 36-765 defines “community health worker” and “practice as a certified community health worker.” From these definitions and requirements established in A.R.S. §§ 36-765.01 through 36-765.06, the Department has drafted new rules for regulating the CHWs certification program at 9 A.A.C. 16, Article 8. Article 8 contains ten new rules that provide definitions (R9-16-801) and CHWs eligibility and scope of practice requirements (R9-16-802), as well as requirements and standards for: CHW trainer qualifications (R9-16-803); initial CHWs application (R9-16-804); certification renewal (R9-16-805); continuing education (R9-16-806); enforcement (R9-16-807); and fees (R9-16-810). Additionally, Laws 2018, Ch. 300, Section 2, established a Community Health Workers Advisory Council to make recommendations to the Director of the Department of Health Care Services regarding: (1) core competencies for certification; (2) minimum education and training qualifications; (3) standards and requirements for education and training programs; (4) standards and requirements for continuing education; (5) minimum education and training standard for educators; and (6) means to assess a CHWs competency for certification. In this rulemaking, the Department has included recommendations made by the CHW Certification Advisory Council, such as minimum age requirement, documentation of 960 hours of experience in the past three years, certification renewal every two years, and 12 hours of continuing education each year. In addition, the Department communicated with the Arizona Health Care Cost Containment System (AHCCCS) to ensure consistence with Medicare and Medicaid and with the Indian Health Services (IHS) to ensure community health representatives may apply for and obtain CHWs certification. The Department reviewed-considered topics and matters identified in the 2017 Sunrise Application Report submitted by the Arizona Community Health Workers Association (AzCHOW) to the Arizona House and Senate requesting voluntary certification and standardization of practice for the profession of Community Health Workers. The Department also communicated with the Division of Public Health

3 “Community health worker” means a nonmedical health worker who serves as a liaison for health and community service providers and enrollees to facilitate access to services and improve the quality of service delivery, including the coordination of services to improve medical and behavioral health outcomes.

4 “Practice as a certified community health worker” means a community health worker's application of the education, training and experience in the core competencies to effectively provide services to the communities and populations that the community health worker serves through one or more of the community health worker's roles.
Prevention, Office of Chronic Disease who funded its first Community Health Worker Team Based Care Model (Model) in 2011 and focused on reducing heart disease at a clinic based in South central Phoenix. A CHW was hired to work side by side with physicians, pharmacists and other clinical staff. The Model was successful, and now, replicated into current Centers for Disease Control and Prevention (CDC) through a Cooperative Agreement. Additionally, the Department in its Health Start Program funds 47 CHW positions who in 2021 completed 19,015 visits to 2,566 families. The Department in this rulemaking supports the certification of CHWs in a manner that is the least burdensome for applicants and increases community health services provided in our State.

The Department anticipates that the cost associated with the rulemaking to be moderate for a rule analyst and program staff to draft new rules in Chapter 16, Article 8 and to communicate with stakeholders to ensure that the Department is aware of concerns stakeholders may have, and, as appropriate, change the draft rules. The Department also expects that the benefit of having the rules will be significant and responsive to the publics call for providing certification of CHWs. Additionally, the Department anticipates that the Department will incur moderate costs to establish a program with staff that will process, review, and approve applications and issue certifications, as specified in the new rules. Further, the Department expects to incur an additional substantial costs for office equipment, development of a computer database for applicants and certified CHWs, creating a CHWs webpage, including updates and maintenance for the two, and other miscellaneous costs for security, utilities, insurances, and the like. The Department expects a significant benefit may occur for having a CHWs Certification Program that ensures CHWs may certify-confirm their skills and proficiencies to provide community health services to clients in Arizona communities.

A.R.S. § 36-765.05 requires the rules “establish and collect nonrefundable fees for certification that are consistent with fees that are prescribed pursuant to Section 36-1908.”

A.R.S. § 36-1908 includes fees for:

1. An original application for regular or temporary license.
2. An original issuance of a regular or temporary license.
3. An original application for a regular or temporary license if an examination pursuant to section 36-1924 is required.
4. A renewal of a regular or temporary license.
5. An issuance of a duplicate regular or temporary license.
6. A late fee.
The Department determined that the fee requirement in A.R.S. § 36-1908 (3) is not applicable for the CHWs rules; and the fee requirement for a late fee, in A.R.S. § 36-1908 (6), will not be included. The Department has, in R9-16-810, established fee requirements consistent with A.R.S. § 36-1908 (1), (2), (4), and (5). The Office of Chronic Disease has communicated with network partners and estimate that there are approximately 1,000 - 1,500 CHWs and Community Health Representatives (CHR) currently employed in Arizona who may have interest in certification. Since the rules are new and the number of applicants that may apply is unknown, the Department, based on knowledge of other-similar types of programs, estimates that 400 applicants may apply during the first year after the rules become effective. The Department, using the estimated number, calculates the CHWs program costs for the first two-years to establish fees for initial application, initial certification, and renewal certification. The cost analysis is documented in Attachment A – CHWs Certification Program Estimated Costs and Fees of this EIS. The fees, referenced above, are established in Section R9-16-810. In addition to fees, R9-16-810 incudes in subsection (E), a waiver for applicants who meet the requirements for waiver of licensing fee provided in A.R.S. § 41-1080.01; and in subsection (F), the Department offers discounted fees for initial application, initial certification, and renewal certification based on available Department funding. The Department expects most funding for discounted fees will come from programs having a CDC grant, such as the Workforce Development Grant, that supports improving and expanding health workers in Arizona. Funds from the Workforce Development Grant support increasing the number of certified CHWs in the Arizona. Other Department programs receiving CDC grants includes Health Disparities, Diabetes, and Chronic Disease Prevention and Health Promotion. The fees, pursuant to statutes, received by the Department is to fund the CHWs certification program and all fees collected will be deposited in the Health Services Licensing Fund established A.R.S. § 36-414. The fees include a: $100 nonrefundable initial application fee; $200 initial certification, and $200 renewal certification. The application fee is a one-time fee and the renewal certification time-period is every two years. After an initial certification, the annual CHWs certification fee is $100 based on the two-year renewal period.

As indicated in Attachment A and statutes, the Department estimates the number of staff, IT resources, and other costs against the estimated number of applicants to determine appropriate fees. The analysis explains Department logic for established CHWs certification fees. Additionally, in looking at the fee structure compared to other professional types, the CHWs fees are not out-of-line or unusually high. The Department does not currently have
another way to pay for the administrative and regulatory work needed, and the legislation does, in fact, create a budget neutral. If the fees are too low and other programs’ licensing fees or general fund support are used, the CHWs program ceases to be budget neutral. The Department anticipates the fees collected will be a significant benefit in support of the CHWs Program budget. Further, the Department agrees that keeping the financial barriers as low as possible is important, and for this reason, has added requirements in R9-16-810 (E) and (F) to reduce applicants’ costs. The Department supports CHWs and agrees with the Arizona State Senate that “a CHW is a [Arizona] frontline public health worker who is a trusted member of, or has an unusually close understanding of, the community served”. This trusting relationship enables the worker to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also “builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.” Having rules that certify CHWs significantly increase the health and safety of Arizonans.

- **Persons (business) who employ certified CHWs and provide support for unpaid certified CHWs (volunteers)**

The Department identifies persons that employ certified CHWs and provide support for unpaid certified CHWs as businesses, small or large, that provide community health services for clients. The community health services are defined in R9-16-801(13) that identifies nonmedical health care related to a CHW's scope of practice and core competencies, whether physical or behavioral health services, for the delivery and coordinated of care overseen by health and community service providers or enrollees that facilitate access services, ref. A.R.S. § 36-765(2), such as Vitalyst Health Foundation, Indian Health Services, Southwest Behavioral & Health Services, AZ Alliance for Community Health Centers, AHCCCS Medicare and Medicaid, and many others. The Department also adds that the health and community service providers, in the [Arizona Health Improvement Plan Summary Document for 2021-2025 (AzHIP Summary Document)](https://www.azleg.gov/legtext/53leg/2R/summary/S.2324_HHS-COMPS_ASPASSEDLOW.pdf) indicates that Arizona continues to experience a shortage of health providers and supports maximum utilization of CHWs and CHRs in clinical settings and adds tactic, page 34, for integration of CHWs into primary care and medical “practices to expand access to care and address social determinants of health”. The

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AzHIP Summary Document also reports that the Arizona health care workforce “has not kept pace with the state’s rapid population growth.” Hence, the Department expects that the Article 8 CHWs rules are important and necessary to assist in increasing-expanding the health and community services provided by health providers and others who facilitate access to community health services necessary to care for all Arizona communities.

The CHWs rules are expected to increase benefits for businesses by not only increasing the quality of care provided to clients, but also by increasing the number of clients receiving care. The Department anticipates that businesses may be more likely to hire CHWs to provide health and community services if a CHW provides a credential that is issued by the Department and demonstrates the CHW’s specific skills, knowledge, and experience related to clients’ care. The rule, in R9-16-802, provides requirements for documentation of a CHW’s age, education, training, and experience. The rule also includes the scope of practice and core competencies that specify topics for which education, trainings, and experience is required. Businesses hiring a certified CHW may receive a significant benefit for knowing that an applicant who is certified meets CHW requirements and approved by the Department as having required skills, knowledge, and experience. Additionally, as a certified CHW, continuing education (CE) is required in R9-16-806, Continuing Education. Having requirements that support maintaining and increasing CHW skills and knowledge over time may also significantly benefit businesses for having certified CHWs whom remain current with topics and quality of care consistently, rather than not at all or as provided by businesses whom may now, because of the rule, reduce the number of in-house trainings or possibility allowing for in-house trainings to be discontinued since certified CHWs will on their own initiative seek out trainings to meet the 24 hours of CEs required by rule for renewing CHW certification. Likewise, businesses may be more likely to accept a certified unpaid CHW rather than a noncertified unpaid CHW, and for the same reason, will most likely receive a significant benefit for not only having a more experience certified unpaid CHW, but for also having an opportunity to hire certified unpaid CHWs who agrees with and supports the businesses’ core values and goals.

The Department anticipates that businesses may incur a minimal cost for CHWs who obtain a CHW certification and for hiring certified CHWs rather than CHWs who do not certified. The Department uses information provided in the U.S. Bureau of Labor Statistics, 2021

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Occupational Employment & Wages Report (2021 Wage Report) to estimate current and potential hourly wages for noncertified and certified CHWs. For CHW wages, the 2021 Wage Report estimates $22.97 as the national mean hourly wage and $47,780 as the national mean annual wage. Note: The 2021 Wage Report does not make a distinction between certified CHWs and noncertified CHWs. Using the 2021 Wage Report, Arizona’s CHWs estimated wages are: $21.27 mean hourly wage and $44,250 median annual wage. The wages for Arizona noncertified CHWs wages are a bit lower that the national wage estimates. The Department’s Health Start Program estimates the average CHW salary at $37,674 annually or $18.15 hourly. The Department used the hourly and annual wages for other states that require CHWs certification to estimate possible wages for future Arizona certified CHWs. The states are identified in Attachment A: CHWs Certification Program Estimated Costs and Fees. Of the five states, hourly wages range from $22.78 (Nevada) and up to $26.88 (New Mexico) and annual wages range from $53,390 (Oregon) to $55,900 (New Mexico). Using the five states that require CHWs be certified, the mean hourly wage is $26.75 and mean annual wage is $55,670. The Department expects that most employed CHWs who obtain a certification will want and may request an increase in salary equivalent to their credentials, and if an increase is not provided, may seek work elsewhere. Businesses that increase certified CHWs wages may receive a significant benefit for keeping trusted employees and the cost of increased wages may be added to costs of community health services, hence, eliminating any increased costs or losses. Additionally, some business, such as Medicaid, do not reimburse noncertified CHWs providing community health services to Medicaid members. Note: AHCCCS-Medicaid regulation specifies reimburse for only certified CHWs whom provide community health services to Medicaid members. Accordingly, some businesses may not experience any increase in costs for employing a certified CHW. The Department does not expect most businesses will incur costs greater than the benefits of employing certified CHWs.

- **Persons who provide CHW trainings:**

  A.R.S. § 36-765.02(A)(5) requires the Director, by rule, to “establish minimum education, training, experience and other qualifications that a certified community health worker must possess to qualify as a trainer in any education, training or continuing education program for certified community health workers.” The CHWs statutes do not provided authority for the
Department to certify by application CHW trainers or to issue CHW Trainer certifications. However, the Department has determined it necessary to issue a certificate to a certified CHW trainer once the Department verifies that the certified CHW meets the qualification requirement in R9-16-803(A). Providing certified CHW trainers a certificate allows individuals and CHWs seeking CHW trainings the ability to ensure trainings and supervision received are consistent with the CHW’s rules. The Department in R9-16-803(A) provides CHW trainer qualifications and specify education and trainings a certified CHW is required to obtain before providing CHW trainings to individuals who wish to practice as a certified community health worker defined in A.R.S. § 36-765(5). The Department, in R9-16-801, also defines “CHW trainer”7. Other requirements in R9-16-803 specify how a certified CHW trainer is to maintain trainer documents stated previously and to comply with requirements relate to the collection of information and records for each individual, noncertified CHW, or certified CHW who receives training and supervision from a certified CHW trainer.

The Department expects that certified CHWs who wish to provide trainings and instructions8 will receive a significant benefit for having rules that clarify the requirements for practicing as a certified CHW trainer. The rules may also provide a significant benefit to certified CHW who wish to provide trainings and supervision to individuals who wish to obtain CHW certification. CHW trainings and supervision are to be consistent with the scope of practice and core competencies specified in this Article. Additionally, the Department expect that continuing education specified in R9-16-806 may provide a significant benefit by clarifying additional types of trainings and supervision a certified CHW trainers may provide to individuals seeking trainings that are consistent with the certified CHW rules. CHWs who currently provide trainings and supervision and complete the requires for certification may incur a minimal cost for having more individuals attending their trainings after the certified CHW obtains a CHW trainer certification. The Department anticipates that after the rules are effective, noncertified CHWs, certified CHWs, and others will seek out CHW trainings and supervision provided by certified CHW trainers.

7 “CHW trainer” means an individual who meets the requirements in R9-16-803 and provides training and supervision to individuals who seek certification as a certified CHW.

8 “Training and instruction” means educational activities that develop and improve an individual’s professional competence in areas related to the practice as a certified CHW specified in A.R.S. § 36-765 and specific to the delivery of services identified in CHW’s scope of practice and core competencies specified in this Article.
Certified CHW trainers who experience an increase in trainings attendance will most likely also experience a significant increase in income-benefit. The Department expects the minimal cost for having more individuals attending trainings will be less than the fees collected for having more attending trainings. The Department does not estimate the increase in demand for CHW trainings and supervision; however, the shortage of health providers and the need to increase the utilization of CHWs in clinical settings, as mentioned in the Arizona Health Improvement Plan, supports reason to believe a significant increase in demand for certified CHWs and certified CHW trainers is expected. The Department expect certified CHW trainers’ fees will be consistent with similar trainings offered by others and are expected to vary based on the level of a topic’s complexity and the amount of instruction time required to adequately present training content, including an examination. In addition, the Department except that certified CHW trainers will most likely offer fees consistent with other trainers, and are reasonable, since, if the fees are too high, individuals and noncertified and certified CHWs will elect to attend trainings offer by others trainers whose fees are affordable.

Additional, certified CHWs who are seeking trainings that satisfy CE requirements specified in R9-16-806 may look to certified CHW trainers for completing CE requirements, since certified CHW trainers’ trainings are consistent with the scope of practice and core competencies specified in the rules. The Department anticipates that certified CHWs trainers could receive a significant benefit should the certified CHW trainers offer trainings specific to CEs. Further, some certified CHW trainers may seek out relationships with employers who wish to provide various trainings for employed certified CHWs and noncertified CHWs. For the employer, increasing employed certified CHWs skills and knowledge will likely increase the types of community health services provided to clients and may increase the number of clients receiving better quality and a greater variety of community health services which is the best outcome for Arizonans.

- **Persons who wish to obtain a CHW certification:**

The Department has identified persons who wish to obtain a CHW certification as individuals that currently provide community health services to clients, are employed or volunteer, and are know as a community health worker (CHW) or a community health representative (CHR). Persons also include individuals in communities, including rural and urban underserved areas, that provide community health services and wish to be certified as a CHW. The Bureau of Chronic Disease and Health Promotion (Bureau) and their network
partners estimate there are approximately 1,000 and 1,500 CHWs and CHRs currently employed in Arizona who may have interest in certification. In addition, the Bureau and network partners agree that it is not likely that all will apply right away for certification, and rather, interest for applying for certification will increase as service providers and health systems representatives support and encourage employees and volunteers to apply for certification. The rules in Article 8 specify CHWs eligibility requirements, scope of practice, and core competencies in R9-16-802; application requirements including documentation demonstrating experience, education, and trainings in R9-16-804; and renewal and continuing education requirements in R9-16-805 and R9-16-806, respectively.

The Department anticipate individuals who wish to obtain a CHW certification will receive a significant benefit for rules that establish a CHW certification program and CHW certification is anticipated to increase opportunities for employment and amount of wages a CHW may received. In R9-16-802(A), a notice is provided and clarifies that a CHW certification is not required to practice as a CHW in Arizona. The Department expect the notice may provide a benefit to individuals who have not yet completed requirements for certification and may determine what additional training and experience is required. These individuals may also receive a benefit from knowing that they may continue to provide community health services without obtaining a CHW certification. Additionally, the notice may benefit volunteers who are questioning whether to certify or not certify since employment may not be a consideration. The cost for filing an application and required documents specified in R9-16-804 may require 4 to 6 hours for an applicant to assemble and submit to application and documents to the Department. The Department expects the application process may cause a minimal cost for applicant. However, the Department also expects that the minimal cost for submitting an application will be decreased by an applicant applying online and from an applicant’s location rather then traveling to the Department of Health Services. Applicants may receive a significant benefit for having rules that provide eligibility requirements that in addition to accepting public education and experience, also accepts paid or volunteer experience equal to or great than 960 hours without having public education or trainings. Additionally, the eligibility requirements includes the National [CHR] Training Program established through the IHS and is expected to provide a significant

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9 IHS Chapter 16 – Community Health Representatives Program
benefit for the many CHR who have completed the training and wish to apply for certification.

A.R.S. § 36-765.05 requires the “Director, by rule, shall establish and collect nonrefundable fees for certification that are consistent with fees that are prescribed pursuant to Section A.R.S. § 36-1908.” Pursuant to A.R.S. § 36-1908 and based on estimated program costs identified in Attachment A, the Department established fees for an initial application, initial certificate, and a renewal application having a two-year time period. The Department anticipate that the fees for CHWs certification may cause some applicants to incur a minimal cost for initial application and initial certification. The Department anticipates that the fees for an initial application fee of $100 and an initial certification fee of $200 is a greater cost for some even though the cost is minimal and less than $1,000. The initial application fee is a one-time fee and provides funding for the Department to establish an IT system and database for the collection of CHWs initial applications, renewals, and other information, as applicable. The Department estimates the cost to be $40,000\textsuperscript{10} and the estimated cost does not include IT system and database system updates/maintenance. The Department expects applicants who receive a CHW certification will over time receive a substantial benefit compared to cost associated with a two-year renewal fee that results in an annual renewal fee of $100. Note: The fees are consistent with statutes and when compared, the fee structure is consistent with other professionals. Additionally, the Department expects CHWs who obtain CHWs certification will receive a significant benefit related to increase opportunities that will allow certified CHWs to become a certified CHW trainer as well as opportunities to seek employment with other service providers that without the CHW certification would not have considered and certified CHWs may receive a significant benefit for being a first choice for a service provider over a noncertified CHW.

Additionally, applicants may receive a significant benefit for having rules that clarify scope of practice and core competencies. For example, before applying for a CHW certification, an applicant may review the rules and determine whether based on their current experience, trainings, and education if additional trainings or hours of experience are requirement. And if required, the applicant may use the rules to determine trainings and experiences that could be completed to satisfy desired eligibility requirement specified R9-16-802(B), (C), and (D). Lastly, the Department expects that after a person is issued a CHW certification the certified

\textsuperscript{10} Attachment A, CHW Certification Program Estimated Costs and Fees

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CHW may incur a minimal cost for having to complete continuing education requirements in addition to completing a renewal application specified in R9-16-806. The Department clarifies that the continuing education requirements are established in A.R.S. § 36-765.02 (A)(4) and Laws 2018, Ch. 300, Sec. 2, for a Community Health Workers Advisory Council (Council) be established by the Department. In Laws 2018, Ch. 300, Sec. 2 (A)(3), the Council was to recommend “standards and requirements for continuing education courses and program.” The Council’s recommendation to the Director stated that a certified CHW complete 12 hours of continuing education annually for a total of 24 hours of continuing education for a renewal certification. The Department anticipates the costs associated with continuing education will vary depending on the type of course a certified CHW attends; some courses may require a preexisting skill set for learning a more technical application and for that reason may be more costly that other courses. The Department has in rule (R9-16-806) simplifies continuing education requirements and provides a list of organizations that offer continuing education courses consistent with the scope of services, core competencies, and direct services related to the rules. Additionally, employers may request an employed certified CHWs to attend specific continuing education courses, and most likely, the employer will provide trainings without cost to the certified CHW. The Department anticipates that these courses will apply towards the renewal continuing education requirements and reducing a certified CHWs costs. Note: The Department expects many organizations offering CHWs continuing education consistent with the rules request fees that are reasonable and affordable. The Department also expects a fair number of continuing education courses will be offered at no charge. The Department expect CHWs will receive significant benefits for completing continuing education courses that increase the types of community health skills a certified CHW may provide, such as completing a course that provides instruction of how to administer a client’s blood pressure. Some courses may not a require fee and others may require a reasonable fee. Since requirements for continuing educations courses are most likely the same courses that many noncertified CHW have already completed, the Department excepts the benefit of completing the required continuing education course will be greater than the fees.

\[\text{A.R.S. § 36-765.02 (A)(4)}\] adopt standards and requirements for the approval or acceptance of continuing education courses and programs for the renewal certification;
• **Clients and the public:**

Clients are defined as individuals receiving community health services provided by a certified CHW. These individuals live in the many communities in Arizona including rural and urban underserved areas. With an increase in the number of certified CHWs in Arizona, the Department expects clients and the public may receive a significant benefit for having an increase in the quality of care and increase in the availability of community health services in their communities. Private persons and consumers are not expected to incur any costs related to the rulemaking since the rules provide certification for CHWs and CHW trainer qualifications. However, persons and persons, who are clients defined in R9-16-801, could receive a significant benefit for having certified CHWs providing community health services in their communities at no cost or, if at a cost, a persons’ health service provider is expected to cover payments for the community health services provided. Certified CHWs serve as an advocate for the health needs of clients and the public by assisting community residents in effectively communicating with their healthcare providers or social service agencies. Additional, certified CHWs may deliver health-related preventive services such as blood pressure, glaucoma, and hearing screening and may collect data to help identify community health needs. Certified CHWs also act as liaisons or advocates and implement programs that promote, maintain, and improve individual and overall community health. The Department believes that clients and the public will receive a significant benefit for having rules that support increasing the number of CHWs in the state and ensures greater protection to the public health and safety for all Arizonans.

4. **A general description of the probable impact on private and public employment in business, agencies, and political subdivisions of this state directly affected by the rulemaking.**

The Department does not expect the rules will have a negative impact on employment for private and public business, agencies, and political subdivisions. Rather, the Department is optimistic that employment will increase as individuals consider employment as a certified CHW who, if not for this rulemaking, would not have considered a career as CHW a profession for consideration. The Department is uncertain how many currently employed CHWs will seek certification and is uncertain as to how many individuals will choose profession as a certified CHW. The Department, as identified in the [Arizona Health Improvement Plan](#), recognizes the need for increasing the number of CHWs in Arizona and anticipates that the rulemaking will create an increase in the number of employed certified CHWs over time. The Department believes the rulemaking will have a positive impact on employment for business, agencies, and political
subdivisions that provide physical health and behavioral health services, such as the Arizona Health Care Cost Containment System, Mercy Maricopa Integrated Care, Department of Health Services, and many other services providers identified in the rulemaking and provide community health services. The Department also considered employment for certified CHW trainers and expect a significant number of CHW trainers will obtain certification. However, the Department anticipates that the number of new certified CHW trainers may be fewer since the eligibility requirements for CHW trainers are more stringent.

5. A statement of the probable impact of the rules on small businesses:
   a. An identification of the small business subject to the rulemaking:
      Small businesses affected by the rulemaking include persons that are certified CHW trainers who provide CHW trainings and supervision and persons that employ certified CHWs.

   b. The administrative and other costs required for compliance with the rules:
      The probable impact of the rules on small businesses include small businesses listed above. The administrative and other costs for certified CHWs trainers is expected to be minimal for having more CHWs attending trainings and supervision. For example, costs could increase for having to acquire additional training materials, hiring an additional certified CHW trainer, as well as additional clerical support to support an increase in administrative activities. Should this occur, the Department expect that the fees collected will be greater than cost incurred. Also, small businesses that employ certified CHWs may incur minimal costs should a noncertified CHWs obtain a CHW certificate. It is reasonable for an employer to increase an employee’s salary for improving and increasing skills, knowledge, and abilities that may increase the types and quality of community health services provided on behalf to the employer. Similarly, a certified CHW providing a variety of community health services to clients should have results that increase revenues and benefits for their employer. Note: The Department does not consider a certified CHWs who wish to applying for CHW trainer certification a small business.

   c. A description of the methods that the agency may use to reduce the impact on small businesses:

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12 A.R.S. § 41-1001(23) “Small business” means a concern, including its affiliates, which is independently owned and operated, which is not dominant in its field and which employs fewer than one hundred full-time employees or which had gross annual receipts of less than four million dollars in its last fiscal year.
The Department knows of no other methods to further reduce the impact on small businesses.

d. The probable costs and benefits to private persons and consumers who are directly affected by the rulemaking:

Private persons and consumers are not expected to incur any costs related to the rulemaking since the rules provide certification for CHWs and CHW trainers qualifications. However, a private person and consumer, who is a client defined in R9-16-801, could receive a significant benefit for having certified CHWs providing community health services in their communities.

6. A statement of the probable effect on state revenues:

The Department does not expect the rules to have an effect on state revenues. The rulemaking includes licensing fees for certified CHWs and potentially civil penalties for persons who violate A.R.S. Title 36, Chapter 16, Article 6, or these rules. A.R.S. § 36-765.05 requires all fees collected be deposited into the health services licensing fund established by A.R.S. § 36-414.

7. A description of any less intrusive or less costly alternative methods of achieving the purpose of the rulemaking:

The Department has determined that there are no less intrusive or less costly alternatives for achieving the purpose of the rulemaking.

8. A description of any data on which the rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data:

Not applicable.
### ATTACHMENT A: CHWs Certification Program Estimated Costs and Fees

<table>
<thead>
<tr>
<th>Personnel and Functions</th>
<th>Est. Annual Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative staff:</strong> assuming 58% of (1) FTE making $50,000/year or (2) FTEs @ 29% each</td>
<td>$29,000</td>
</tr>
<tr>
<td>– Process initial applications and verify documentation, including verification of qualifications</td>
<td></td>
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<tr>
<td>– Process renewal applications; verify documentation and continuing education</td>
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<tr>
<td>– Process request for change affecting a CHWs license</td>
<td></td>
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<tr>
<td>– Assist applicant to complete applications, and respond for other public questions and comments</td>
<td></td>
</tr>
<tr>
<td>– Enforcement: complaint investigates/responses/reports</td>
<td></td>
</tr>
<tr>
<td>– Update CHWs database and webpages</td>
<td></td>
</tr>
<tr>
<td>– Administration time for rulemaking process</td>
<td></td>
</tr>
</tbody>
</table>

| Supervisor: assuming 13.3% of FTE making $60,000/year                                   | $8,000            |
| – Supervise administrative staff                                                        |                   |
| – Respond to public comments and questions                                               |                   |
| – Complaint assessments/responses/reports                                               |                   |
| – Administration of database for CHWs data                                              |                   |
| – Administration of webpage, including all forms, applications, and other required electronic documents; identify and approve continuing education applicable to CHWs and CHW trainers | |
| – Process fees and maintain accounting records                                           |                   |
| – Administration time for rulemaking process; tracking legislative activities/A.R.S. amends | |

| Other indirect cost:                                                                     | $10,000           |
| – Equipment: computers, printers, telephones, including other office materials           |                   |
| – ITS services for developing CHWs application process-database, updates, and maintenance|                   |
| – ITS webpage development, updates, and maintenance                                     |                   |
| – Office space and materials                                                             |                   |
| – Rent, security, utilities, insurance, etc.                                             |                   |

**Total average DHS annual costs for CHWs Program**  | $47,000            |

**One-time cost for database, webpage development** | $40,000            |

**DHS costs for first two-year certification:**  | $134,000           |

| DHS costs for first two-year certification renewal:                                   | $94,000 |

**First year:** application $100 + initial license $200; $300 collected x 400 applicants = $120,000 fees collected for 2-year period.

**First two-years:** $134,000 less one-time $40,000 = $94,000/[400 applicants x 2-year period] = average cost per year/applicant $117.50

**An average of:** ($17.50)(2) = ($35)(400) = $14,000. The average is equal to DHS shortage expected to occur during first renewal.

**First renewal:** license $200 x 400 applicants = $80,000; Department costs are $94,000; DHS collects $80,000; DHS shortage of $14,000.

- **Connecticut:** $100 certificate; renewal every three years  
  [Population: 3.565 million]  
  ARIZONA 7.279 million; PHOENIX 1.633 million

- **Nevada:** $75 for CHW 1; $150 for CHW 2; renewal every year; and first aid, TB, and background verification is required.  
  [Population 3.08 million]

- **New Mexico:** requires background check ($44 fee); certificate valid for two years; application fee $45 for generalist certification and an additional $10 for each specialty area added.  
  [Population: 1.097 million, Albuquerque 559,374]

- **Rhode Island:** $125 certification; recertification every two years.  
  [Population: 1.059 million]

- **Oregon:** required traditional health workers (CHWs) to complete Oregon Health Authority approved training, be at least 18 years of age; pass a background checks (OAR 410-180-0325), and compete continuing education; certification valid for 36 months; FEES: 331-655-0005. Application $125, original issuance of license is $125 for one year, and renewal of license $125.  
  [Population: 4.218 million]

**Note:** CDC Report cites nine states offer voluntary CHW certification Arizona, Florida, Indian, Massachusetts, New Mexico Ohio, Oregon, Rhode Island, and Texas. Other states are setting a side statewide certification and instead are focusing on other strategies for CHW workforce development, including expanding training. July 2018.
Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

The table of contents on page one contains links to the referenced page numbers in this Chapter. Refer to the notes at the end of a Section to learn about the history of a rule as it was published in the Arizona Administrative Register.

This Chapter contains rules that were filed to be codified in the Arizona Administrative Code between the dates of April 1, 2022 through June 30, 2022.

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<td>R9-16-116</td>
<td>Denial, Suspension, or Revocation of License; Civil Penalties; Procedures</td>
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Questions about these rules? Contact:

Department: Department of Health Services
Public Health Licensing Services
Address: 150 N. 18th Ave., Suite 400
Phoenix, AZ 85007
Website: [www.azdhs.gov](http://www.azdhs.gov)
Name: Megan Whitby, Bureau Chief
Telephone: (602) 364-3052
Fax: (602) 364-2079
Email: Megan.Whitby@azdhs.gov

The release of this Chapter in Supp. 22-2 replaces Supp. 20-3, 1-47 pages

Please note that the Chapter you are about to replace may have rules still in effect after the publication date of this supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.
PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), Administrative Rules Division, accepts state agency rule notice and other legal filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION

RULES
The definition for a rule is provided for under A.R.S. § 41-1001. “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE
The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions.

The Code is separated by subject into Titles. Titles are divided into Chapters. A Chapter includes state agency rules. Rules in Chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering outline separated into subsections.

Rules are codified quarterly in the Code. Supplement release dates are printed on the footers of each Chapter.

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2022 is cited as Supp. 22-1. Supplements are traditionally released three to four weeks after the end of the quarter because filings are accepted until the last day of the quarter.

Please note: The Office publishes by Chapter, not by individual rule Section. Therefore there might be only a few Sections codified in each Chapter released in a supplement. This is why the Office lists only updated codified Sections on the previous page.

RULE HISTORY
Refer to the HISTORICAL NOTE at the end of each Section for the effective date of a rule. The note also includes the Register volume and page number in which the notice was published (A.A.R.) and beginning in supplement 21-4, the date the notice was published in the Register.

AUTHENTICATION OF PDF CODE CHAPTERS
The Office began to authenticate Chapters of the Code in Supp. 18-1 to comply with A.R.S. § 41-1012(B) and A.R.S. § 5302(1), (2)(d) through (e), and (3)(d) through (e).

A certification verifies the authenticity of each Code Chapter posted as it is released by the Office of the Secretary of State. The authenticated pdf of the Code includes an integrity mark with a certificate ID. Users should check the validity of the signature, especially if the pdf has been downloaded. If the digital signature is invalid it means the document’s content has been compromised.

HOW TO USE THE CODE
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

ARIZONA REVISED STATUTE REFERENCES
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a Chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES
Arizona Session Law references in a Chapter can be found at the Secretary of State’s website, www.azsos.gov under Services-> Legislative Filings.

EXEMPTIONS FROM THE APA
It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the Register online at www.azsos.gov/rules, click on the Administrative Register link.

Editor’s notes at the beginning of a Chapter provide information about rulemaking Sections made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

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Rhonda Paschal, rules managing editor, assisted with the editing of this Chapter.
ARTICLE 1. LICENSING OF MIDWIFERY

Editor's Note: Historical references to repealed Table 1 and Exhibits A through E, moved to the end of the Article for codification scheme continuity (Supp. 22-2).

Article 1, consisting of Sections R9-16-101 through R9-16-112 and Exhibits A through E, adopted as noted in Section Historical Notes (Supp. 94-I).

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In addition to the definitions in A.R.S. § 36-751, the following definitions apply in this Article unless otherwise specified:

1. “Amniotic” means the fluid surrounding a fetus while in the mother’s uterus.
2. “Apgar score” means the number indicating a newborn’s physical condition, attained by rating selected body functions.
3. “Breech” means a complete breech, a frank breech, or an incomplete breech.
4. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, state-wide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, state-wide furlough day, or legal holiday.

“Certified nurse midwife” means an individual who meets the criteria in 4 A.A.C. 19, Article 5, and is certified by the Arizona State Board of Nursing.

“Cervix” means the narrow lower end of the uterus that protrudes into the cavity of the vagina.

“Client” means a pregnant woman accepted by a midwife for the purpose of receiving a written or verbal recommendation and implementing prospective advice regarding the care of a pregnant woman or the woman’s fetus or newborn.

“Dilation” means opening of the cervix during the mechanism of labor to allow for passage of the fetus.

“Effacement” means the gradual thinning of the cervix during the mechanism of labor and indicates progress in labor.

“Emergency care plan” means the arrangements established by a midwife for a client’s transfer of care in a situation in which the health or safety of the client or newborn is determined to be at risk.

“Emergency medical services provider” has the same meaning as in A.R.S. § 36-2201.

“Episiotomy” means the cutting of the perineum, at the center, middle, or midline, in order to enlarge the vaginal opening for delivery.

“Fetus” means a child in utero from conception to birth.

“Frank breech” means that, at the time of birth, the buttocks of a fetus are pointing downward with both legs folded at the knees and the feet near the buttocks.

“Gestation” means the length of time from conception to birth, as calculated from the first day of the last normal menstrual period.

“Incomplete breech” means that, at the time of birth, the buttocks of a fetus are pointing downward with one leg folded flat up against the head.

“Gestational age” means the number of weeks from conception to birth, calculated from the first day of the last normal menstrual period.

“Incomplete breech” means that, at the time of birth, the buttocks of a fetus are pointing downward with one leg folded at the knee with the foot near the buttock.

“Informed consent” means a document signed by a client, as provided in R9-16-109, agreeing to the provision of midwifery services.

“Jurisprudence test” means an assessment of an individual’s knowledge of the:
   a. Laws of this state concerning the reporting of births, prenatal blood tests, and newborn screening; and
   b. Rules pertaining to the practice of midwifery.

“Ketones” means certain harmful chemical elements that, when present in the body in excessive amounts, results in compromised bodily function.

“Meconium” means the first bowel movement of the newborn, which is greenish black in color and tarry in consistency.

“Midwifery services” means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery, or postpartum care.

“Newborn” has the same meaning as in A.R.S. § 36-694.

“Perineum” means the muscular region in the female between the vaginal opening and the anus.

“Physician” means an allopathic, an osteopathic, or a naturopathic practitioner licensed according to A.R.S. Title 32, Chapter 13, 14, or 17.

“Postpartum” means the six-week period following delivery of a newborn and placenta.

“Prenatal” means the period from conception to the onset of labor and birth.

“Prenatal visit” means each clinical examination of a pregnant woman for the purpose of monitoring the course of gestation and the overall health of the woman.

“Quickening” means the first perceptible movement of the fetus in the uterus, occurring usually in the 16th to the 20th week of gestation.

“Rh” means a blood antigen.

“Transfer of care” means that a midwife refers the care of a client or newborn to an emergency medical services provider, a certified nurse midwife, a hospital, or a physician who then assumes responsibility for the direct care of the client or newborn.

“Working day” means a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a state-wide furlough day.

### Historical Note

Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Section amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).
The Department shall provide to an applicant a written notice

The Department shall issue an initial license to practice midwifery within five working days after receiving the applicable documentation and licensing fee required in subsection (E).

If an applicant receives notification of eligibility to take the jurisprudence test, the Department shall provide written notice of the notification in subsection (D) to the applicant, within five working days after the date of the notification.

Current documentation of completion of training in:

1. Adult basic cardiopulmonary resuscitation through a course recognized by the American Heart Association;
2. Neonatal resuscitation through a course recognized by the American Academy of Pediatrics or American Heart Association;
3. Documentation of a high school diploma, a high school equivalency diploma, an associate degree, or a higher degree;
4. Documentation that the applicant is certified by the North American Registry of Midwives as a Certified Professional Midwife;
5. Except as provided in subsection (B), a non-refundable application fee of $25; and
6. A non-refundable testing fee of $100 for a jurisprudence test administered by the Department.

An applicant is not required to submit the fee in subsection (A) if the applicant does not:

1. Shall take the jurisprudence test administered by the Department,
2. Shall provide proof of identity by a government-issued photographic identification card upon the request of the individual administering the jurisprudence test,
3. May take the jurisprudence test as many times as desired, without paying an additional testing fee, and
4. Shall score 80% or higher correct answers on the jurisprudence test to be eligible to receive an initial license to practice midwifery.

If an applicant scores 80% or higher correct answers on the jurisprudence test, the Department shall provide written notice to the applicant, within five working days after the date of the jurisprudence test, to submit to the Department:

1. Except as provided in subsection (B), a licensing fee of $25; and
2. The documentation required in subsection (A)(4) or (6), if the documentation of training required in subsection (A)(4) or certification required in subsection (A)(6) is not current.

The Department shall issue an initial license to practice midwifery within five working days after receiving the applicable documentation and licensing fee required in subsection (E).

The Department shall provide to an applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A) and inform the applicant that the applicant may reapply under subsection (A) if the applicant does not:

1. Score 80% or higher correct answers on the jurisprudence test within 180 calendar days after the date of the notification of eligibility to take the jurisprudence test, or
2. Submit to the Department the applicable documentation and licensing fee required in subsection (D) within 120 calendar days after the date of the notification in subsection (D).

Historical Note
Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Amended by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Section R9-16-102 repealed; new Section R9-16-102 renumbered from R9-16-103 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-103. License Renewal
A. At least 30 calendar days and no more than 60 calendar days before the expiration date of a midwifery license, a midwife shall submit to the Department:
1. An application for renewal of a midwifery license, in a format provided by the Department, that contains:
   a. The midwife’s name, address, telephone number, and e-mail address;
   b. The midwife’s license number;
   c. Whether the midwife has been convicted of a felony or a misdemeanor in this or another state or jurisdiction in the previous two years;
   d. If the midwife was convicted of a felony or misdemeanor:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the midwife was convicted, and
      iv. The disposition of the case;
   e. Whether the midwife agrees to allow the Department to submit supplemental requests for information under R9-16-107(C)(2);
   f. An attestation that the midwife has completed the continuing education requirement in R9-16-105;
   g. An attestation that the midwife is complying with the requirements in A.R.S. § 32-3211;
   h. An attestation that information required as part of the application is true and accurate; and
   i. The midwife’s signature and date of signature;
2. Either:
   a. Documentation that the midwife is currently certified by the North American Registry of Midwives as a Certified Professional Midwife;
   b. For a midwife who has been continuously licensed as a midwife by the Department since 1999, a copy of both sides of documentation showing the completion of current training in:
      i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
      ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b); and
3. A non-refundable renewal fee of $25.

B. The Department shall review an application for renewal of a license to practice midwifery according to R9-16-107 and Table 1.1.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1). Section R9-16-103 renumbered to R9-16-102; new Section R9-16-103 made by exempt rulemaking at 19 A.A.R. 1805,
CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

R9-16-104. Administration
A. A midwife may submit a written request for the Department to:
   1. Add the midwife’s name, address, and telephone number to a list of licensed midwives on the Department’s website; or
   2. Remove the midwife’s name, address, and telephone number from a list of licensed midwives on the Department’s website.
B. A midwife shall:
   1. Notify the Department in a format provided by the Department within five working days after:
      a. A client has died while under the midwife’s care,
      b. A stillborn child has been delivered by the midwife, or
      c. A newborn delivered by the midwife has died within the first six weeks after birth; and
   2. Provide a summary of the:
      a. Circumstances leading up to the event, and
      b. Actions taken by the midwife in response to the event.
C. A midwife shall:
   1. Maintain documentation of:
      a. Completion of current training in:
         i. Adult basic cardiopulmonary resuscitation that meets the requirements in R9-16-102(A)(4)(a), and
         ii. Neonatal resuscitation that meets the requirements in R9-16-102(A)(4)(b);
      b. Except as provided in R9-16-103(A)(2)(b), current certification as a Certified Professional Midwife by the North American Registry of Midwives; and
      c. The continuing education required in subsection R9-16-105 for at least the previous three years; and
   2. Provide a copy of documentation required in subsection (C)(1) to the Department within two working days after the Department’s request.

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1). Section repealed; new Section made by final expedited rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-105. Continuing Education
During the term of a midwifery license, the midwife shall obtain at least 20 hours of continuing education that:
1. Improve the midwife’s ability to:
   a. Provide services within the midwife’s scope of practice,
   b. Recognize and respond to situations outside the midwife’s scope of practice, or
   c. Provide guidance to other services a client may need; and
2. Have been approved as applicable to the practice of midwifery by the:
   a. American Nurses Association,
   b. American Congress of Obstetrics and Gynecologists,
   c. Midwives Alliance of North America,
   d. Arizona Medical Association,
   e. American College of Nurse Midwives,
   f. Midwifery Education Accreditation Council, or
   g. Another health professional organization.

Historical Note
Adopted effective March 14, 1994, except for subsections (B)(3) and (C) which are effective September 15, 1994 (Supp. 94-1). Section repealed; new Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

R9-16-105.01. Repealed

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Section repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

R9-16-106. Name Change; Duplicate License
A. To request a name change on a midwifery license or a duplicate midwifery license, a midwife shall submit in writing to the Department:
   1. The midwife’s name on the current midwifery license;
   2. If applicable, the midwife’s new name;
   3. The midwife’s address, license number, and e-mail address;
   4. As applicable:
      a. Documentation supporting the midwife’s name change, or
      b. A statement that the midwife is requesting a duplicate midwifery license; and
   5. A non-refundable fee of $10.00.
B. Upon receipt of the written request required in subsection (A), the Department shall issue, as applicable:
   1. An amended midwifery license that incorporates the name change but retains the expiration date of the midwifery license; and
   2. A duplicate midwifery license.

Historical Note

R9-16-107. Time-frames
A. The overall time-frame described in A.R.S. § 41-1072(2) for each type of license granted by the Department is specified in Table 1.1. The applicant or midwife and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25 percent of the overall time-frame.
B. The administrative completeness review time-frame described in A.R.S. § 41-1072(1) for each type of license granted by the Department is specified in Table 1.1.
   1. The administrative completeness review time-frame begins:
      a. For an applicant submitting an application for an initial license, when the Department receives the application packet required in R9-16-102(A); and
      b. For a licensed midwife applying to renew a midwifery license, when the Department receives the application packet required in R9-16-103(A).
2. If an application is complete, the Department shall provide to the applicant or midwife, during the administrative completeness review time-frame:
   a. A notice of administrative completeness, or
   b. A notice of eligibility to take the jurisprudence test or a license.
3. If an application is not complete, the Department shall provide a notice of deficiencies to the applicant or midwife describing the missing documentation or incomplete information.
   a. The administrative completeness review time-frame and the overall time-frame are suspended from the date of the notice until the date the Department receives the documentation or information listed in the notice of deficiencies.
   b. An applicant or midwife shall submit to the Department the documentation or information listed in the notice of deficiencies in subsection (B)(3) within the time specified in Table 1.1 for responding to a notice of deficiencies.
   c. If the applicant or midwife submits the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall provide a written notice of administrative completeness to the applicant or midwife.
   d. If the applicant or midwife does not submit the documentation or information listed in the notice of deficiencies within the time specified in Table 1.1, the Department shall consider the application withdrawn.

C. The substantive review time-frame described in A.R.S. § 41-1072(3) is specified in Table 1.1 and begins on the date of the notice of administrative completeness.
   1. If an application complies with the requirements in this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.
   2. If an application does not comply with the requirements in this Article or A.R.S. Title 36, Chapter 6, Article 7, the Department shall make one comprehensive written request for additional information, unless the applicant or midwife has agreed in writing to allow the Department to submit supplemental requests for information.
      a. The substantive review time-frame and the overall time-frame are suspended from the date that the Department sends a comprehensive written request for additional information or a supplemental request for information until the date that the Department receives all of the information requested.
      b. An applicant or midwife shall submit to the Department all of the information requested in a comprehensive written request for additional information or a supplemental request for information in subsection (C)(2) within the time specified in Table 1.1.
      c. If the applicant or midwife does not submit the additional information within the time specified in Table 1.1 or the additional information submitted by the applicant or midwife does not demonstrate compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall provide to the applicant a written notice of denial that complies with A.R.S. § 41-1092.03(A).
      d. If the applicant or midwife submits the additional information within the time specified in Table 1.1 and the additional information submitted by the applicant or midwife demonstrates compliance with this Article and A.R.S. Title 36, Chapter 6, Article 7, the Department shall issue a notice of eligibility to take the jurisprudence test to an applicant or a license to a midwife.

**Historical Note**


Table 1.1. Time-frames (in calendar days)

<table>
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<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-Frame</th>
<th>Administrative Completeness Review Time-Frame</th>
<th>Time to Respond to Notice of Deficiency</th>
<th>Substantive Review Time-Frame</th>
<th>Time to Respond to Comprehensive Written Request</th>
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<td>Eligibility for Jurisprudence Test (R9-16-102)</td>
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<td>15</td>
<td>60</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Midwifery License Renewal (R9-16-103)</td>
<td>A.R.S. § 36-754</td>
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<td>15</td>
<td>30</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

**Historical Note**

Table 1.1 made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

**R9-16-108. Responsibilities of a Midwife: Scope of Practice**

A. A midwife shall provide midwifery services only to a woman:
   1. Who does not have any of the conditions specified in R9-16-111(B) through (E) or another condition that may increase the risk of harm to the woman or the woman’s fetus or newborn during pregnancy or labor, as determined through a physical assessment and review of the woman’s medical history and past pregnancies; and
   2. Whose expected outcome of pregnancy is most likely to be the delivery of a newborn, with none of the conditions requiring transfer of care as specified in R9-16-111(J)(1), and an intact placenta.

B. Except as provided in R9-16-111(C) or (D), a midwife who is certified by the North American Registry of Midwives as a Certified Professional Midwife may accept a client for a vaginal delivery:
   1. After prior Cesarean section, or
   2. Of a fetus in a complete breech or frank breech presentation.
I. During the prenatal period, the midwife shall:

1. Inform the pregnant woman, both orally and in writing, of:
   a. The midwife’s scope of practice, educational background, and credentials, as specified in R9-16-102(A)(4) and (6) as applicable;
   b. if applicable to the pregnant woman’s condition, the midwife’s experience with:
      i. Vaginal birth after prior Cesarean section delivery, or
      ii. Delivery of a fetus in a complete breech or frank breech presentation;
   c. The potential risks; adverse outcomes; neonatal or maternal complications, including death; and alternatives associated with an at-home delivery specific to the pregnant woman’s condition, including the conditions described in subsection (C)(1)(b);
   d. The requirement for tests specified in subsections (I) and (K)(3)(c), and the potential risks for declining a test, and, if a test is declined, the need for a written assertion of a pregnant woman’s decision to decline testing;
   e. The requirement for consultation for a condition specified in R9-16-112; and
   f. The requirement for the transfer of care for a condition specified in R9-16-111; and

2. Obtain a written informed consent for midwifery services according to R9-16-109.

D. A midwife shall:

1. Establish an emergency care plan for a client that includes:
   a. The name of the client;
   b. The name of the midwife;
   c. The name, address, and phone number of:
      i. The hospital closest to the birthing location that provides obstetrical services, and
      ii. An emergency medical services provider that provides service between the birthing location and the hospital identified in subsection (D)(1)(c)(i);
   d. The signature of the client and the date signed; and
   e. The signature of the midwife and the date signed; and

2. For a delivery identified in subsection (B), ensure that the hospital identified in subsection (D)(1)(c)(i) is within 25 miles of the birthing location.

E. A midwife shall ensure the client receives a copy of the emergency care plan required in subsection (D).

F. A midwife shall implement the emergency care plan by immediately calling the emergency medical services provider identified in subsection (D)(1)(c)(ii) for any condition that threatens the life of the client or the client’s fetus or newborn.

G. A midwife shall maintain all instruments used for delivery in a germ-free manner and other birthing equipment and supplies in clean and good condition.

H. A midwife shall assess a client’s physical condition in order to establish the client’s continuing eligibility to receive midwifery services.

I. During the prenatal period, the midwife shall:

1. Except as provided in R9-16-110, ensure that the following tests are completed by the client within 28 weeks gestation:
   a. Blood type, including ABO and Rh, with antibody screen;
   b. Urinalysis;
9. Review with the client the circumstances when a transfer of care is required, as specified in R9-16-111.

J. During the intrapartum period from the onset of labor until after the delivery of the placenta, a midwife shall:
   1. Determine if the client is in labor and the appropriate course of action to be taken by:
      a. Assessing the interval, duration, intensity, location, and pattern of the contractions;
      b. Determining the condition of the membranes, including whether the membranes are intact or ruptured, and the amount and color of fluid;
      c. Reviewing with the client the need for fluid intake related to subsection (J)(3)(d), relaxation, and activity; and
      d. Deciding whether to go to the client’s home or other birthing location, remain in telephone contact, or arrange for transfer of care or consultation;
   2. Contact the hospital identified in subsection (D)(1)(c)(i) according to the policies and procedures established by the hospital regarding communication with midwives when the client begins labor and ends labor;
   3. During labor:
      a. Assess the condition of the client and fetus:
         i. Upon initial contact;
         ii. Every half hour during active labor until completely dilated; and
         iii. Every 15 to 20 minutes during pushing, following rupture of the amniotic bag, or until the newborn is delivered;
      b. Include in the assessments required in subsection (J)(3)(a):
         i. A physical assessment and checking of the client’s vital signs every two to four hours; and
         ii. Assessing fetal heart tones every 30 minutes during active first stage labor, and every 15 minutes during second stage labor, following rupture of the amniotic bag, or with any significant change in labor patterns;
      c. Periodically assess contractions, fetal presentation, dilation, effacement, and fetal position by vaginal examination;
      d. Maintain proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones; and
      e. Assist in support and comfort measures to the client and family;
   4. For deliveries described in subsection (B), during labor determine the progression of active labor:
      a. For a pregnant woman giving birth to her first newborn, by monitoring whether dilation occurs at an average of one centimeter per hour until completely dilated, and a second stage does not exceed two hours;
      b. For a pregnant woman who has previously given birth to one or more newborns, by monitoring whether dilation occurs at an average of 1.5 to two centimeters per hour until completely dilated, and a second stage does not exceed one hour; or
      c. According to the Management Guidelines recommended by the American Congress of Obstetricians and Gynecologists;
   5. After delivery of the newborn:
      a. Assess the newborn at one minute and five minutes to determine the Apgar scores;
      b. Physically assess the newborn for any abnormalities;
      c. Inspect the client’s perineum, vagina, and cervix for lacerations;
      d. Deliver the placenta within 1 hour and assess the client for signs of placental separation from the inner wall of the uterus, resulting in vaginal or internal bleeding; and
      e. Examine the placenta for intactness and to determine the number of umbilical cord vessels; and
   6. Recognize and respond to any situation requiring immediate intervention, including measures to be taken during an emergency, as specified in R9-16-113.

K. During the postpartum period, the midwife shall:
   1. During the two hours after delivery of the placenta, provide the following care to the client:
      a. Every 15 to 20 minutes for the first hour and every 30 minutes for the second hour:
         i. Take vital signs of the client,
         ii. Perform external massage of the uterus, and
         iii. Evaluate bleeding;
      b. Assist the client to urinate within two hours following the birth;
      c. Evaluate the perineum, vagina, and cervix for tears, bleeding, or blood clots;
      d. Assist with maternal-newborn bonding to develop a relationship between the client and newborn;
      e. Assist with initial breast feeding, instructing the client in the care of the breast, and reviewing potential danger signs, if appropriate;
      f. Provide instruction to the family about:
         i. Fluid and nutritional intake requirements to meet the needs of the mother and newborn;
         ii. Rest and the types of exercise allowed;
         iii. Normal and abnormal bleeding, bladder and bowel function;
         iv. How to care for the newborn;
         v. Signs and symptoms of postpartum depression; and
         v. Any symptoms that may pose a threat to the health or life of the client or the client’s newborn and appropriate emergency phone numbers;
      g. Recommend, or administer under physician’s written orders, Rho immunoglobulin to an unsensitized Rh-negative client who delivers an Rh-positive newborn so that administration occurs within 72 hours after birth; and
      h. Document any medications or vitamins to the newborn in the client’s record;
   2. During the two hours after delivery of the placenta, provide the following care to the newborn:
      a. Perform a newborn physical assessment to determine the newborn’s gestational age and any abnormalities;
      b. Comply with the requirements in A.A.C. R9-6-338;
      c. Recommend, or administer under physician’s written orders, Vitamin K to the newborn so that administration occurs within 72 hours after birth; and
      d. Document the physical assessment and administration of any medications or vitamins to the newborn in the newborn’s record according to the physician’s written orders;
   3. Evaluate the client or newborn for any abnormal or emergency situation and seek consultation or intervention, if applicable, according to these rules; and
CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

A midwife shall ensure that a copy of the written informed consent for midwifery services in a format provided by the Department that contains:

1. The midwife’s:
   a. Name;
   b. Telephone number;
   c. License number;
   d. E-mail address;
2. The client’s:
   a. Name;
   b. Address;
   c. Telephone number;
   d. Date of birth;
   e. E-mail address, if applicable;
3. An attestation that the client was:
   a. Was provided the information as required in R9-16-108(C)(1)(d), and
   b. Is declining testing; and
4. The signatures of the client and midwife and date signed.

A midwife shall ensure that a copy of the written informed consent for midwifery services is placed in the client record.

A midwife shall ensure that a copy of the written informed consent for midwifery services is provided to the:

1. Client, and
2. Department within five calendar days after a Department request.

R9-16-110. Assertion to Decline Required Tests

A. Except for R9-16-108(I)(1)(f), if the client declines a test required in R9-16-108(I)(1) or (2), a midwife shall obtain a written assertion of a client’s decision to decline a required test in a format provided by the Department, that contains:

1. The midwife’s:
   a. Name;
   b. Telephone number;
   c. License number, and
   d. E-mail address;
2. The client’s:
   a. Name;
   b. Address;
   c. Telephone number;
   d. Date of birth; and
   e. E-mail address, if applicable;
3. The required test being declined by the client;
4. Additional information as required by the Department;
5. An attestation that the client:
   a. Was provided the information as required in R9-16-108(C)(1)(d), and
   b. Is declining testing; and
6. The signatures of the client and midwife and date signed.

B. A midwife shall ensure that the written assertion of the decision to decline a test is placed in the client record.

C. A midwife shall ensure that a copy of the written assertion of the decision to decline a test is provided to:

1. Client, and
2. Department within five calendar days after a Department request.

R9-16-111. Prohibited Practice; Transfer of Care

A. A midwife shall not provide midwifery services in a location that has the potential to cause harm to the client or the client’s fetus or newborn.

B. A midwife shall not accept as a client for midwifery services a pregnant woman who has any of the following:

1. A previous surgery that involved:
   a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
   b. A previous uterine surgery that enters the myometrium;
C. A midwife shall not continue midwifery services for a client who is diagnosed with or develops any of the following:
1. Any condition specified in subsections (B)(4) through (16);
2. A hematocrit below 30 during the third trimester;
3. Except as provided in R9-16-108(B)(2), a fetus that is not in a head-down position with the crown of the head being the leading body part;
4. Labor beginning before the beginning of 36 weeks gestation;
5. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
6. A gestation beyond 42 weeks;
7. Presence of ruptured membranes without onset of labor within 24 hours;
8. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
9. Presence of thick meconium, bloody-stained amniotic fluid, or abnormal fetal heart tones;
10. A postpartum hemorrhage of greater than 500 milliliters in the current pregnancy; or
11. A non-bleeding placenta retained for more than 60 minutes.

D. A midwife shall not perform a vaginal delivery after prior Cesarean section for a client who:
1. Had:
   a. More than one previous Cesarean section;
   b. A previous Cesarean section:
      i. With a classical, vertical, or unknown uterine incision;
      ii. Within 18 months before the expected delivery;
      iii. With complications, including uterine infection;
      iv. Due to failure to progress as a result of cephalopelvic insufficiency; or
   c. Complications during a previous vaginal delivery after a Cesarean section; or
2. Has a fetus:
   a. With fetal anomalies, confirmed by an ultrasound; or
   b. In a breech presentation.

E. A midwife shall not perform a vaginal delivery of a fetus in a breech presentation for a client who:
1. Had a previous:
   a. Unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis, or
   b. Cesarean section; or
2. Has a fetus:
   a. With fetal anomalies, confirmed by an ultrasound;
   b. With an estimated fetal weight less than 2500 grams or more than 3800 grams; or
   c. In an incomplete breech presentation.

F. If the client has any of the conditions in subsections (C) through (E), a midwife shall:
1. Document the condition in the client record, and
2. Initiate transfer of care.

G. A midwife shall not perform any operative procedures except as provided in R9-16-113.

H. A midwife shall:
1. Use any artificial, forcible, or mechanical means to assist birth; or
2. Attempt to correct fetal presentations by external or internal movement of the fetus.

I. A midwife shall not administer drugs or medications except as provided in R9-16-108(I)(3)(f), (K)(1)(g), or (K)(2)(c), or R9-16-113.

J. Except as provided in R9-16-113, a midwife shall:
1. Discontinue midwifery services and transfer care of a newborn in which any of the following conditions are present:
   a. Birth weight less than 2000 grams;
   b. Pale, blue, or gray color after 10 minutes;
   c. Severe swelling, especially of the newborn’s abdomen;
   d. Major congenital anomalies; or
   e. Respiratory distress; and
2. Document the condition in subsection (J)(1) in the newborn record.

Historical Note
A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:
   1. A positive culture for Group B Streptococcus;
   2. History of seizure disorder;
   3. History of stillbirth, premature labor, or having delivered more than five newborns;
   4. Age younger than 16 years;
   5. A first pregnancy in a client older than 40 years of age;
   6. Failure to auscultate fetal heart tones by the beginning of 22 weeks gestation;
   7. Failure to gain 12 pounds by the beginning of 30 weeks gestation or gaining more than eight pounds in any two-week period during pregnancy;
   8. Greater than 1% sugar, ketones, or protein in the urine on two consecutive visits;
   9. Excessive vomiting or continued vomiting after the end of 20 weeks gestation;
   10. Symptoms of decreased fetal movement;
   11. A fever of 100.4° F or 38° C or greater measured twice at 24 hours apart;
   12. Tender uterine fundus;
   13. Effacement or dilation of the cervix, greater than a finger-tip, accompanied by contractions, prior to the beginning of 36 weeks gestation;
   14. Measurements for fetal growth that are not within 2 centimeters of the gestational age;
   15. Second degree or greater lacerations of the birth canal;
   16. As provided in R9-16-111(C)(4), a progression of labor that does not follow the guidelines in R9-16-108(J)(4)(e);
   17. An unengaged head at seven centimeters dilation in active labor;
   18. Failure of the uterus to return to normal size in the current postpartum period;
   19. Persistent shortness of breath requiring more than 24 breaths per minute, or breathing which is difficult or painful;
   20. Gonorrhea;
   21. Chlamydia;
   22. Syphilis;
   23. Heart disease;
   24. Kidney disease;
   25. Blood disease; or
   26. A positive test result for:
      a. HIV;
      b. Hepatitis B, or
      c. Hepatitis C.

B. A midwife shall obtain a consultation at the time a newborn demonstrates any of the following conditions:
   1. Weight less than 2500 grams or five pounds, eight ounces;
   2. Congenital anomalies;
   3. An Apgar score less than 7 at five minutes;
   4. Persistent breathing at a rate of more than 60 breaths per minute;
   5. An irregular heartbeat;
   6. Persistent poor muscle tone;
   7. Less than 36 weeks gestation or greater than 42 weeks gestation by gestational exam;
   8. Yellowish-colored skin within 48 hours;
   9. Abnormal crying;
   10. Meconium staining of the skin;
   11. Lethargy;
   12. Irritability;
   13. Poor feeding;
   14. Excessively pink coloring over the entire body;
   15. Failure to urinate or pass meconium in the first 24 hours of life;
   16. A hip examination which results in a clicking or incorrect angle;
   17. Skin rashes not commonly seen in the newborn; or
   18. Temperature persistently above 99.0° or below 97.6° F.

C. The midwife shall inform the client of the consultation required in subsections (A) or (B) and recommendations of the physician or certified nurse midwife.

D. The midwife shall document the consultation required in subsections (A) or (B) and recommendations received in the client record or newborn record, as specified in R9-16-115(B)(14) or (C)(7) as applicable.

Historical Note
C. A midwife shall document in the client’s record any medications taken by a client for the control of postpartum hemorrhage.

**Historical Note**

New Section R9-16-113 renumbered from R9-16-110 and amended by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-16-114. Midwife Report after Termination of Midwifery Services**

A. A midwife shall complete a midwife report for each client, in a format provided by the Department, that includes the following:

1. The midwife’s:
   a. First name,
   b. Last name, and
   c. License number;

2. The client’s:
   a. Date of birth;
   b. Client number;
   c. Date of last menstrual period;
   d. Estimated date of delivery;
   e. Gravida, the number of times the client has been pregnant, including a current pregnancy, regardless of whether these pregnancies were carried to term;
   f. Para, the number of times the client has given birth at greater than 20 weeks of gestation, including viable and non-viable births, where multiples are counted as one birth; and
   g. If applicable, whether the client had a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation;

3. A description of the maternal outcome, including any complications;

4. If a vaginal delivery after prior Cesarean section or vaginal delivery of a fetus in a complete breech or frank breech presentation:
   a. Rate of dilation, and
   b. Duration of second stage labor;

5. If applicable, the newborn’s:
   a. Date of birth;
   b. Gender;
   c. Weight;
   d. Length;
   e. Head circumference;
   f. Designation of average, small, or large for gestational age;
   g. Apgar score at one minute;
   h. Apgar score at five minutes;
   i. Existence of complications;
   j. Description of complications, if applicable;
   k. Birth certificate filing date; and
   l. Birth certificate number, if available;

6. Whether the client required transfer of care and, if applicable:
   a. Method of transport,
   b. Type of facility or individual to which the midwife transferred care of the client,
   c. Name of destination,
   d. Time arrived at destination,
   e. Confirmation the emergency care plan was utilized, and
   f. Medical reason for transfer of care;

7. The date midwifery services were terminated;
8. Reason for the termination of midwifery services;
9. If termination of midwifery services was due to a medical condition, the specific medical condition;
10. Whether information was provided on newborn screening; and
11. Whether newborn screening tests were ordered as required in A.R.S. § 36-694.

B. The midwife shall submit a midwife report for a client to the Department within 30 calendar days after the termination of midwifery services to the client.

**Historical Note**

Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section amended by final expedited rulemaking at 28 A.A.R. 1119 (May 27, 2022), with an immediate effective date of May 4, 2022 (Supp. 22-2).

**R9-16-115. Client and Newborn Records**

A. A midwife shall ensure that a record is established and maintained according to A.R.S. §§ 12-2291 and 12-2297 for each:

1. Client, and
2. Newborn delivered by the midwife from a client.

B. A midwife shall ensure that a record for each client includes the following:

1. The client’s full name, date of birth, address, and client number;
2. Names, addresses, and telephone numbers of the client’s spouse or other individuals designated by the client to be contacted in an emergency;
3. Written informed consent for midwifery services, as required in R9-16-110(A);
4. A copy of the emergency care plan, as required in R9-16-110(D);
5. The date the midwife began providing midwifery services to the client;
6. The date the client is expected to deliver the newborn;
7. The date the midwife delivered the newborn, if applicable;
8. The date the newborn was delivered, if applicable;
9. An initial assessment of the client to:
   a. Determine whether the client has a history of a condition or circumstance that would preclude care of the client by the midwife, as specified in R9-16-111; and
   b. Determine the:
      i. Number and outcome of previous pregnancies, and
      ii. Number of previous medical or midwife visits the client has had during the current pregnancy;
10. Progress notes documenting the midwifery services provided to the client;
11. For a delivery identified in R9-16-108(B):
   a. Rate of dilation, and
   b. Duration of second stage labor;
12. Laboratory and diagnostic reports, required in R9-16-108(I);
13. Documentation of consultations as required in R9-16-112, including:
   a. Reason for the consultation,
   b. Name of physician or certified nurse midwife contacted,
   c. Date of consultation,
   d. Time of consultation,
C. A midwife shall ensure that a record for each newborn includes the following:
1. The full name, date of birth, and address of the newborn’s mother;
2. The newborn’s:
   a. Date of birth,
   b. Gender,
   c. Weight at birth,
   d. Length at birth, and
   e. Apgar scores at one minute and five minutes after birth;
3. The newborn’s estimated gestational age at birth;
4. Progress notes documenting the midwifery services provided to the newborn;
5. Laboratory and diagnostic reports, as required in R9-16-108(I);
6. Documentation of consultations as required in R9-16-112, including:
   a. Reason for the consultation,
   b. Name of physician or certified nurse midwife contacted,
   c. Date of consultation,
   d. Time of consultation,
   e. Recommendation made by the physician or certified nurse midwife, and
   f. Actions taken as a result of the consultation;
7. Any written reports received from consultations required in R9-16-112;
8. A description of any conditions or circumstances arising during or after the newborn’s birth that required the transfer of care;
9. The name of the physician, certified nurse midwife, or hospital to which the care of the newborn was transferred, if applicable;
10. Documentation of medications or vitamins taken by the newborn;
11. Documentation of medications or vitamins administered to the newborn and the physician’s written orders for the medications or vitamins;
12. Documentation of newborn screening, including when the specimen collection kit, as defined in A.A.C. R9-13-201, was submitted and results received, as required in R9-16-108(K)(4)(c);
13. The date the midwife stopped providing midwifery services to the newborn; and
14. Instructions provided to the client about the newborn before the midwife stopped providing midwifery services to the newborn.

Historical Note

R9-16-116. Denial, Suspension, or Revocation of License; Civil Penalties; Procedures
In addition to the grounds specified in A.R.S. §§ 13-904(E) and 36-756, the Department may deny, suspend, or revoke a license permanently or for a definite period of time, and may assess a civil penalty for each violation, for any of the following causes:
1. Practicing under a false name or alias so as to interfere with or obstruct the investigative or regulatory process,
2. Practicing under the influence of drugs or alcohol,
3. Falsification of records,
4. Obtaining any fee for midwifery services by fraud or misrepresentation,
5. Permitting another to use the midwife’s license,
6. Knowingly providing false information to the Department.

Historical Note

R9-16-117. Expired

Historical Note
New Section made by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2). Section expired under A.R.S. § 41-1056(J) at 23 A.A.R. 1044, effective August 26, 2017 (Supp. 17-3).

Table 1. Repealed

Historical Note
Table 1 made by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2). Table 1 repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit A. Repealed

Historical Note
Section repealed, new Section adopted effective March 14, 1994 (Supp. 94-1). Exhibit A repealed by final rulemaking at 8 A.A.R. 2896, effective June 18, 2002 (Supp. 02-2).

Exhibit B. Repealed

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1). Exhibit B repealed by exempt rulemaking at 19 A.A.R. 1805, effective July 1, 2013 (Supp. 13-2).

Exhibit C. Repealed

Historical Note
Adopted effective March 14, 1994 (Supp. 94-1). Exhibit
ARTICLE 2. LICENSING AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS

R9-16-201. Definitions

1. “Accredited” means approved by the:
   a. New England Commission of Higher Education,
   b. Middle States Commission on Higher Education,
   c. Higher Learning Commission,
   d. Northwest Commission on Colleges and Universities,
   e. Southern Association of Colleges and Schools Commission on Colleges,
   f. WASC Senior College and University Commission.
2. “Applicant” means an individual who submits an application and required documentation for approval to practice as an audiologist or a speech-language pathologist.
3. “ASHA” means the American Speech-Language-Hearing Association, a national professional, scientific, and credentialing association for audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.
4. “Calendar day” means each day, not including the day of the act, event, or default, from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
5. “CCC” means Certificate of Clinical Competence, an award issued by ASHA to an individual who:
   a. Completes a degree in audiology or speech-language pathology from an accredited college or university that includes a clinical practicum,
   b. Passes the ETSNEA or ETSNESLP, and
   c. Completes a clinical fellowship.
6. “Clinical fellow” means an individual engaged in a clinical fellowship.
7. “Clinical fellowship” means an individual’s postgraduate professional experience assessing, diagnosing, screening, treating, writing reports, and counseling individuals exhibiting speech, language, hearing, or communication disorders, obtained:
   a. After completion of graduate level academic course work and a clinical practicum;
   b. Under the supervision of a clinical fellowship supervisor; and
   c. While employed on a full-time or part-time equivalent basis.
8. “Clinical fellowship agreement” means the document submitted to the Department by a clinical fellow to register the initiation of a clinical fellowship.
9. “Clinical fellowship report” means a document completed by a clinical fellowship supervisor containing:
   a. A summary of the diagnostic and therapeutic procedures performed by the clinical fellow,
   b. A verification by the clinical fellowship supervisor of the clinical fellow’s performance of diagnostic and therapeutic procedures, and
   c. An evaluation of the clinical fellow’s ability to perform the diagnostic and therapeutic procedures.
10. “Clinical fellowship supervisor” means a licensed speech-language pathologist who:
    a. Is or has been a sponsor of a temporary licensee,
    b. Had a CCC while supervising a clinical fellow before October 28, 1999, or
    c. Has a CCC while supervising a clinical fellow in another state.
11. “Clinical practicum” means the experience acquired by an individual who is completing course work in audiology or speech-language pathology, while supervised by a licensed audiologist, a licensed speech-language pathologist, or an individual holding a CCC, by assessing, diagnosing, evaluating, screening, treating, and counseling individuals exhibiting speech, language, cognitive, hearing, or communication disorders.
12. “Continuing education” means a course that provides instruction and training that is designed to develop or improve a licensee’s professional competence in disciplines directly related to the licensee’s scope of practice.
13. “Course” means a workshop, seminar, lecture, conference, or class.
14. “Diagnostic and therapeutic procedures” means the principles and methods used by an audiologist in the practice of audiology or a speech-language pathologist in the practice of speech-language pathology.
15. “Disciplinary action” means a proceeding that is brought against a licensee by the Department under A.R.S. § 36-1934 or a state licensing entity.
16. “ETSNEA” means Educational Testing Service National Examination in Audiology, the specialty area test of the Praxis Series given by the Education Testing Service, Princeton, N.J.
17. “ETSNESLP” means Educational Testing Service National Examination in Speech-Language Pathology, the specialty area test of the Praxis Series given by the Education Testing Service, Princeton, N.J.
18. “Full-time” means 30 clock hours or more per week.
20. “Local education agency” means a governing board established by A.R.S. § 15-101 or A.R.S. Title 15, Chapter 3, Article 3.
21. “Monitoring” means being responsible for and providing direction to a clinical fellow without directly observing diagnostic and therapeutic procedures.
22. “On-site observations” means the presence of a clinical fellowship supervisor who is watching a clinical fellow.
23. “Part-time” means:
    a. 25-29 clock hours per week for 48 weeks,
    b. 20-24 clock hours per week for 60 weeks, or
    c. 15-19 clock hours per week for 72 weeks.
24. “Semester credit hour” means one earned academic unit of study based on completing, at an accredited college or university, a 50 to 60 minute class session per calendar week for 15 to 18 weeks.
25. “Semester credit hour equivalent” means one quarter credit, which is equal in value to 2/3 of a semester credit hour.
26. “State-supported institution” means a school, a charter school, a private school, or an accommodation school as defined in A.R.S. § 15-101.
27. “Student” means a child attending a school, a charter school, a private school, or an accommodation school as defined in A.R.S. § 15-101.
28. “Supervision” means being responsible for and providing direction to:
   a. A clinical fellow during on-site observations or monitoring of the clinical fellow’s performance of diagnostic and therapeutic procedures; or
   b. An individual completing a clinical practicum.
29. “Supervisory activities” means evaluating and assessing a clinical fellow’s performance of diagnostic and therapeutic procedures in assessing, diagnosing, evaluating, screening, treating, and counseling individuals exhibiting speech, language, cognitive, hearing, or communication disorders.

Historical Note
Former Section R9-16-201 repealed, new Section R9-16-201 adopted effective January 23, 1978 (Supp. 78-1).
Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-202. Application
A. An applicant for licensure shall submit to the Department:
1. An application in a Department-provided format that contains:
   a. The applicant’s name, home address, telephone number, and e-mail address;
   b. The applicant’s Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
   c. If applicable, the applicant’s business addresses and telephone number;
   d. The applicant’s current employment, if applicable, including:
      i. The employer’s name,
      ii. The licensee’s position,
      iii. Dates of employment,
      iv. The address of the employer,
      v. The supervisor’s name,
      vi. The supervisor’s email address, and
      vii. The supervisor’s telephone number;
   e. If applicable, whether the applicant is requesting an audiology license to fit and dispense;
   f. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state;
   g. If the applicant has been convicted of a felony or a misdemeanor:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the applicant was convicted, and
      iv. The disposition of the case;
   h. Whether the applicant is or has been licensed as an audiologist, an audiologist to fit and dispense hearing aids, or a speech-language pathologist in another state or country;
   i. Whether the applicant has had a license revoked or suspended by any state;
   j. Whether the applicant is currently ineligible for licensing in any state because of a license revocation or suspension;
   k. Whether any disciplinary action has been imposed by any state, territory or district in this country for an act related to the applicant’s practice of audiology or a speech-language pathologist license;
   l. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-214(C);
   m. An attestation that the information submitted as part of the application is true and accurate; and
   n. The applicant’s signature and date of signature;
2. If a license for the applicant has been revoked or suspended by any state documentation that includes:
   a. The date of the revocation or suspension,
   b. The state or jurisdiction of the revocation or suspension, and
   c. An explanation of the revocation or suspension;
3. If the applicant is currently ineligible for licensing in any state because of a license revocation or suspension, documentation that includes:
   a. The date of the ineligibility for licensing,
   b. The state or jurisdiction of the ineligibility for licensing, and
   c. An explanation of the ineligibility for licensing;
4. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant’s license to practice audiology or a speech-language pathologist license that is consistent with A.R.S. Title 36, Chapter 17, documentation that includes:
   a. The date of the disciplinary action,
   b. The state or jurisdiction of the disciplinary action,
   c. An explanation of the disciplinary action, and
   d. Any other applicable documents, including a legal order or settlement agreement;
5. Documentation of the applicant’s citizenship or alien status that complies with A.R.S. § 41-1080; and
6. A fee specified in R9-16-216.
B. In addition to complying with subsection (A), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:
1. The name of each state that issued the applicant a current license, including:
   a. The license number of each current license, and
   b. The date each current license was issued;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
   b. Has met minimum education requirements according to A.R.S. §§ 36-1940 or 36-1940.01;
c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and 
d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.

C. The Department shall review the application and required documentation for a license according to R9-16-214 and Table 2.1.

Historical Note
Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-203. Initial Application for an Audiologist
A. In addition to complying with R9-16-202, an applicant for initial licensure as an audiologist shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant from an accredited college or university after the applicant’s completion of a doctoral degree consistent with the standards of this state’s universities, as required in A.R.S. § 36-1940(A)(2) or documentation of the applicant’s current CCC.
2. Documentation of a passing grade on an ETSNEA or current CCC dated within three years before the date of application required in A.R.S. §§ 36-1902(E) and 36-1940(A)(3) or current license from other state.
3. Documentation of completing supervised clinical rotation consistent with the standards of this state’s universities required in A.R.S. § 36-1940(B)(2) or current CCC.
4. Whether the applicant is applying to fit and dispense hearing aids.
5. If applicable, a list of all states and countries in which the applicant is or has been licensed as an audiologist or an audiologist to fit and dispense hearing aids.

B. In addition to complying with R9-16-202, an applicant for initial licensure as an audiologist licensed to fit and dispense hearing aids who was awarded a master’s degree before December 31, 2007 shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant from an accredited college or university demonstrating the applicant’s completion of a master’s degree in audiology before December 31, 2007 or documentation of the applicant’s current CCC;
2. Documentation of a passing grade on an ETSNEA or current CCC dated within three years before the date of application; and
3. Documentation of a passing grade obtained by the applicant on a written hearing aid dispenser examination as required in A.R.S. § 36-1940(C)(4).

Historical Note
Former Section R9-16-203 repealed, new Section R9-16-203 adopted effective January 23, 1978 (Supp. 78-1).
Repealed effective March 14, 1994 (Supp. 94-1).


R9-16-204. Initial Application for a Speech-language Pathologist
A. In addition to complying with R9-16-202(A), an applicant for initial licensure as a speech-language pathologist shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant by an accredited college or university after the applicant’s completion of a master’s degree consistent with the standards of this state’s universities, as required in A.R.S. § 36-1940.01(A)(2)(a) or documentation of current CCC;
2. Completion of a clinical practicum, as required in A.R.S. § 36-1940.01(A)(2)(b) or documentation of current CCC;
3. Documentation of the applicant’s completion of the ETS- NESLP as required in A.R.S. § 36-1940.01(A)(3) or documentation of current CCC; and
4. Documentation of the completion of clinical fellowship or documentation of current CCC.

Historical Note
Former Section R9-16-204 repealed, new Section R9-16-204 adopted effective January 23, 1978 (Supp. 78-1).
Repealed effective March 14, 1994 (Supp. 94-1).

R9-16-205. Initial Application for a Temporary Speech-language Pathologist
A. In addition to complying with R9-16-202(A), an applicant for initial licensure as a temporary speech-language pathologist shall submit to the Department the following:
1. A transcript or equivalent documentation issued to the applicant by an accredited college or university after the applicant’s completion of a master’s degree consistent with the standards of this state’s universities, as required in A.R.S. § 36-1940.01(A)(2)(a).
2. Completion of a clinical practicum, as required in A.R.S. § 36-1940.01(A)(2)(b).
3. Documentation of the applicant’s completion of the ETS- NESLP as required in A.R.S. § 36-1940.01(A)(3).
4. Documentation of the applicant’s clinical fellowship agreement that includes:
   a. The applicant’s name, home address, and telephone number;
   b. The clinical fellowship supervisor’s name, business address, telephone number, and speech-language pathology license number;
   c. The name and address where the clinical fellowship will take place;
Before the expiration date of a license, a licensee shall submit:

A. A renewal application in a Department-provided format that contains:
   a. The licensee’s name, home address, telephone number, and e-mail address;
   b. If applicable, the licensee’s business address and telephone number;
   c. The licensee’s current employment, if applicable, including:
      i. The employer’s name,
      ii. The licensee’s position,
      iii. Dates of employment,
   d. A statement by the clinical fellowship supervisor agreeing to comply with R9-16-209; and
   e. The signatures of the applicant and the clinical fellowship supervisor.

B. A temporary license issued is effective for 12 months from the date of issuance.

C. A temporary license may be renewed only once.

D. An applicant issued a temporary speech-language pathologist license shall:
   1. Practice under the supervision of a licensed speech-language pathologist, and
   2. Not practice under the supervision of an individual who has a temporary speech-language pathologist license.

Historical Note

R9-16-206. Requirements for a Speech-language Pathologist - Limited
In addition to complying with R9-16-202(A), an applicant for initial licensure as a speech-language pathologist - limited as specified in A.R.S. § 36-1940.01(B) shall submit to the Department the following:
1. A certificate in speech and language therapy awarded by the Department of Education.
2. A document representing an employee or contractor relationship with a local education agency or a state supported institution.

Historical Note

R9-16-207. License Renewal
A. Before the expiration date of a license, a licensee shall submit to the Department:
   1. A renewal application in a Department-provided format that contains:
      a. The licensee’s name, home address, telephone number, and e-mail address;
      b. If applicable, the licensee’s business address and telephone number;
      c. The licensee’s current employment, if applicable, including:
         i. The employer’s name,
         ii. The licensee’s position,
         iii. Dates of employment,
      d. The address of the employer,
      e. The supervisor’s name,
      f. The supervisor’s email address, and
      g. The supervisor’s telephone number;
   d. The licensee’s license number and date of expiration;
   e. Since the previous license application, whether the licensee has been convicted of a felony or a misdemeanor in this or another state;
   f. If the licensee was convicted of a felony or a misdemeanor:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the licensee was convicted, and
      iv. The disposition of the case;
   g. Whether the licensee has had, within two years before the renewal application date, an audiology or speech-language pathology license suspended or revoked by any state;
   h. If the applicant has been disciplined by any state, territory, or district of this country for an act related to the applicant’s license to practice audiology or a speech-language pathologist license that is consistent with A.R.S. Title 36, Chapter 17, documentation that includes:
      i. The date of the disciplinary action,
      ii. The state or jurisdiction of the disciplinary action,
      iii. An explanation of the disciplinary action, and
      iv. Any other applicable documents, including a legal order or settlement agreement;
   i. An attestation that the licensee completed continuing education required under A.R.S. § 36-1904 and documentation of completion is available upon request;
   j. The licensee agrees to allow the Department to submit supplemental requests for information under R9-16-214(C);
   k. An attestation that the information submitted as part of the application is true and accurate; and
   l. A renewal fee specified in R9-16-216.
B. A licensee licensed as a speech-language pathologist, whose practice is limited to providing services to students under the authority of a local education agency or state-supported institution, shall provide documentation required in A.R.S. § 36-1940.01(B);
C. If a licensee is renewing a temporary speech-language pathology license:
   1. A statement signed and dated by the licensee’s clinical fellowship supervisor agreeing to comply with R9-16-209; and
   2. The name, business address, telephone number, and license number of the speech language pathologist providing supervision to the licensee.
D. In addition to subsection (A), a licensee who submits a renewal application within 30 calendar days after the license expiration date shall submit a late fee specified in R9-16-216.
E. A licensee who does not submit the documentation and the fee in subsection (A) and, if applicable, (B) within 30 calendar days after the license expiration date shall apply for a new license in R9-16-202.
F. If a licensee applies for a license according to R9-16-202 more than 30 calendar days but less than one year after the expiration date of the applicant’s previous license, the applicant:
1. Is not required to submit ETSNEA or ETSNESLP documentation, and
2. Shall submit an attestation of continuing education according to R9-16-208, completed within the twenty-four months before the date of application.

G. The Department shall review the application for a renewal license according R9-16-214 and Table 2.1.

Historical Note

R9-16-208. Continuing Education
A. Twenty-four months prior to submitting a renewal application, a licensee shall complete continuing education.
1. Except as provided in (A)(2), a licensed audiologist shall complete at least 20 continuing education hours related to audiology;
2. A licensed audiologist who fits and dispenses hearing aids shall complete:
   a. At least 20 continuing education hours related to audiology and hearing aid dispensing, and
   b. No more than eight continuing education hours required in subsection (A)(2)(a) provided by a single manufacturer of hearing aids; and
3. A licensed speech-language pathologist shall complete at least 20 continuing education hours in speech-language pathology related courses.

B. Continuing education shall:
1. Directly relate to the practice of audiology, speech-language pathology, or fitting and dispensing hearing aids;
2. Have educational objectives that exceed an introductory level of knowledge of audiology, speech-language pathology, or fitting and dispensing hearing aids; and
3. Consist of courses that include advances within the last five years in:
   a. Practice of audiology,
   b. Practice of speech-language pathology,
   c. Procedures in the selection and fitting of hearing aids,
   d. Pre- and post-fitting management of clients,
   e. Instrument circuitry and acoustic performance data,
   f. Ear mold design and modification contributing to improved client performance,
   g. Audiometric equipment or testing techniques that demonstrate an improved ability to identify and evaluate hearing loss,
   h. Auditory rehabilitation,
   i. Ethics,
   j. Federal and state statutes or rules, or
   k. Assistive listening devices.

C. A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):
1. Hearing Healthcare Providers of Arizona,
2. Arizona Speech-Language-Hearing Association,
3. American Speech-Language-Hearing Association,
4. International Hearing Society,
iv. Notation of speech-language pathologist assistant’s progress;
d. Documentation of evaluations provided to the speech-language pathologist assistant during the time supervision was provided; and
e. Documentation of when supervision was terminated; and

2. Maintain a speech-language pathologist assistant record:
   a. Throughout the period that the speech-language pathologist assistant receives direct supervision and indirect supervision clinical interactions from the supervisor; and
   b. For at least two years after the last date the speech-language pathologist assistant received clinical interactions from the supervisor.

Historical Note

R9-16-211. Equipment; Records
A. A licensee shall maintain equipment used by the licensee in the practice of audiology or the practice of speech-language pathology according to the manufacturer’s specifications.

B. If a licensee uses equipment that requires calibration, the licensee shall ensure that:
   1. The equipment is calibrated a minimum of every 12 months and according to the American National Standard - Specifications for Audiometers S3.6-2018, incorporated by reference and on file with the Department, with no future additions or amendments and available from the Standards Secretariat, c/o Acoustical Society of America, 1305 Walt Whitman Road, Suite 300, Melville, New York, 11747-4300, September 20, 2018; and
   2. A written record of the calibration is maintained in the same location as the calibrated equipment for at least 36 months after the date of the calibration.

C. A licensee shall maintain the following records according to A.R.S. § 32-3211 for each client for at least 36 months after the date the licensee provided a service or dispensed a product while engaged in the practice of audiology, practice of speech-language pathology, or practice of fitting and dispensing hearing aids:
   1. The client’s name, address, and telephone number;
   2. The name or description and the results of each test and procedure used in evaluating speech, language, and hearing disorders or determining the need for dispensing a product or service; and
   3. If a product such as a hearing aid, augmentative communication device, or laryngeal device is dispensed, a record of the following:
      a. The name of the product dispensed;
      b. The product’s serial number, if any;
      c. The product’s warranty or guarantee, if any;
      d. The refund policy for the product, if any;
      e. A statement of whether the product is new or used;
      f. The total amount charged for the product;
      g. The name of the licensee; and
      h. The name of the intended user of the product.

Historical Note

R9-16-212. Bill of Sale Requirements
An audiologist who dispenses hearing aids shall provide a bill of sale to a client at the time the audiologist provides a hearing aid to the client or at a time requested by the client that complies with the requirements in R9-16-311(A)(7).

Historical Note

R9-16-213. Enforcement
A. The Department may, as applicable:
   1. Deny, revoke, or suspend an audiology or speech-language pathology’s license under A.R.S. § 36-1934; or
   2. Request an injunction under A.R.S. § 36-1937; or
   3. Assess a civil money penalty under A.R.S. § 36-1939.

B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:
   1. The type of violation,
   2. The severity of the violation,
   3. The danger to the public health and safety,
   4. The number of violations,
   5. The number of clients affected by the violations,
   6. The degree of harm to the consumer,
   7. A pattern of noncompliance, and
   8. Any mitigating or aggravating circumstances.

C. A licensee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

R9-16-214. Time-frames
A. For each type of license issued by the Department under this Article, Table 2.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
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1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.

2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.

B. For each type of license issued by the Department under this Article, Table 2.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).

1. The administrative completeness review time-frame begins the date the Department receives an application required in this Article.

2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
   a. If a license application is not complete, the notice of deficiencies listing each deficiency and the information or documentation needed to complete the application.
   b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
   c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.

3. If the Department issues a license during the administrative completeness review time-frame, the Department shall issue a regular license or a temporary license:
   a. Two years, if a regular license, and
   b. Twelve months, if a temporary license.

C. For each type of license issued by the Department under this Article, Table 2.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date the Department sends a written notice of administrative completeness.

1. Within the substantive review time-frame, the Department shall provide a written notice to the applicant that the Department approved or denied.

   a. If the Department may make one comprehensive written request for additional information or documentation;
   b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.

3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.

4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the license or approval.

D. The Department shall issue a regular license or a temporary license:
   1. Within five calendar days after receiving the license fee, and
   2. From the date of issue, the license is valid for:
      a. Two years, if a regular license, and
      b. Twelve months, if a temporary license.

E. An applicant who is denied a license may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

Table 2.1 Time-frames (in calendar days)

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<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-Frame</th>
<th>Administrative Completeness Review Time-Frame</th>
<th>Time to Respond to Notice of Deficiency</th>
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<tr>
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<td>A.R.S. §§ 36-1904 and 36-1940</td>
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<td>License Renewal (R9-16-207)</td>
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<td>60</td>
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Historical Note
Table 2.1 made by exempt rulemaking under R9-16-209 at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Table 2.1 repealed; new Table 2.1 made and recodified under new Section R9-16-214, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-215. Changes Affecting a License or a Licensee; Request for a Duplicate License

A. A licensee shall submit to the Department a notice in a Department-provided format within 30 calendar days after the effective date of a change in:
   1. The licensee’s home address or e-mail address, including the new home address or e-mail address;
   2. The licensee’s name, including a copy of one of the following with the licensee’s new name:
      a. Marriage certificate,
      b. Divorce decree, or
      c. Other legal document establishing the licensee’s new name; and
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3. The place or places, including address or addresses, where the licensee engages in the practice of audiology or speech-language pathology.

B. A licensee may obtain a duplicate license by submitting to the Department a written request for a duplicate license in a format provided by the Department that includes:
   1. The licensee’s name and address,
   2. The licensee’s license number and expiration date,
   3. The licensee’s signature and date of signature, and
   4. A duplicate license fee specified in R9-16-216.

Historical Note

R9-16-216. Fees
A. An applicant shall submit to the Department the following nonrefundable fee for:
   1. An initial application as an audiologist, $100;
   2. An initial application as a speech-language pathologist, $100; and
   3. An initial application as a temporary speech-language pathologist, $100.

B. An applicant shall submit to the Department the following fee for:
   1. An initial license as an audiologist, $200;
   2. An initial license as a speech-language pathologist, $200; and
   3. A temporary license as a speech-language pathologist, $100.

C. A licensee shall submit to the Department the following fee for:
   1. A renewal license as an audiologist, $200;
   2. A renewal license as a speech-language pathologist, $200; and
   3. A temporary renewal license as a speech-language pathologist, $100.

D. If a licensed audiologist or speech-language pathologist submits a renewal license application specified in subsection (C) within 30 calendar days after the license expiration date, the licensee shall submit with the renewal license application a $25 late fee.

E. The fee for a duplicate license is $25.

F. An applicant for initial licensure is not required to submit the applicable fee in subsection (A) and (B) if the applicant, as part of the applicable application in R9-16-202, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

Historical Note
New Section made by final expedited rulemaking at 26 A.A.R. 816, with an immediate effective date of April 8, 2020 (Supp. 20-2).

ARTICLE 3. LICENSING HEARING AID DISPENSERS

R9-16-301. Definitions
In addition to the definitions in A.R.S. § 36-1901, the following definitions apply in this Article unless otherwise specified:
   1. “Applicant” means an individual or a business organization that submits an application and required documentation for approval to practice as a hearing aid dispenser.
   3. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

   4. “Continuing education” means a course that provides instruction and training that directly relates to the practice of fitting and dispensing hearing aids specified in A.R.S. § 36-1904.

   5. “Designated agent” means an individual who:
      a. Is authorized by an applicant or hearing aid dispenser [a person] to receive communications from the Department, including legal service of process;
      b. May file or sign documents on behalf of the applicant or hearing aid dispenser;
      c. Is a U.S. citizen or legal resident; and
      d. Has an Arizona address; and
      e. Is a controlling person of the business organization, if applicable.

   6. “Disciplinary action” means a proceeding that is brought against a licensee by the Department under A.R.S. § 36-1934 or a state specified in R9-16-308(A)(2).

   7. “GED” means a general education development test.

   8. “Hearing aid dispenser examination” means one of the following that has been identified by the Department as complying with the requirements in A.R.S. § 36-1924:
      a. The International Licensing Examination for Hearing Health Professionals, administered by the International Hearing Society; or
      b. A test provided by the Department or other organization.

   9. “Practical examination” means a test:
      a. Designated by the Department that demonstrates an applicant’s proficiency in the practice of fitting and dispensing of hearing aids, and

10. “State licensing entity” means a state agency or board that approves licensure and takes disciplinary action of individuals or businesses that practice as a hearing aid dispenser.

   11. “Temporary hearing aid dispenser” means a person who is licensed under A.R.S. Title 36, Chapter 17 and this Article for a specified period of time under the sponsorship of a hearing aid dispenser also licensed under A.R.S. Title 36, Chapter 17 and this Article.

Historical Note

R9-16-302. Examination Requirements
A. Within two years after the date an applicant receives the approval notification in R9-16-306(B), or a temporary hearing aid dispenser receives the approval in R9-16-305(B), the applicant or temporary hearing aid dispenser shall take and obtain a passing score on the Department-designated:
   1. Written hearing aid dispenser examination required in subsection (B), and
   2. Practical examination required in subsection (B).

B. An applicant approved to take the Department-designated practical examination or a temporary hearing aid dispenser approved to take the Department-designated practical examination shall:
1. Arrive on the scheduled date and time of the examination;
2. Provide proof of identity by a government-issued photographic identification card that is provided by the applicant or temporary hearing aid dispenser upon the request of the individual administering the examination, and
3. Exhibit ethical conduct during the examination process.

C. After the Department receives an applicant’s Department-designated written hearing aid dispenser examination results, the Department shall notify the applicant of:
   1. A passing score and approval to take the practical examination;
   2. A failing score that includes, as applicable, approval to retake the written hearing aid dispenser examination.

D. An applicant or temporary hearing aid dispenser who does not comply with subsection (B)(1) or (B)(2) is ineligible to take the examination on the scheduled date and time.

E. An applicant or temporary hearing aid dispenser taking the examination will receive a passing score on the examination if the applicant or temporary hearing aid dispenser demonstrates the proficiencies in A.R.S. § 36-1924, as determined by the Department.

F. After the Department receives an applicant’s practical examination results, the Department shall notify the applicant whether the applicant received:
   1. A passing score; or
   2. A failing score and, as applicable, approval to retake the Department-designated practical examination for the examination sections that the applicant failed.

G. The Department shall notify an applicant or temporary hearing aid dispenser that the applicant or temporary hearing aid dispenser may apply for an initial hearing aid dispenser license when the applicant or temporary hearing aid dispenser has received a passing score on both of the examinations in subsection (A).

Historical Note

R9-16-304. Application
A. An applicant for licensure shall submit to the Department:
   1. An application in a Department-provided format that contains:
      a. The applicant’s name, home address, telephone number, and e-mail address;
      b. The applicant’s Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
      c. The applicant’s current employment, if applicable, including:
         i. The employer’s name,
         ii. The licensee’s position,
         iii. Dates of employment,
         iv. The address of the employer,
         v. The supervisor’s name,
         vi. The supervisor’s email address, and
         vii. The supervisor’s telephone number;
      d. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state or jurisdiction;
      e. If the applicant was convicted of a felony or misdemeanor:
         i. The date of the conviction,
      f. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-314;
      g. An attestation that the information submitted as part of the application is true and accurate; and
      h. The applicant’s signature and date of signature;
   2. Documentation of the applicant’s citizenship or alien status that complies with A.R.S. § 41-1080;
   3. Documentation that the applicant received a high school diploma, a high school equivalency diploma, an associate degree, or a higher degree;
   4. Whether a professional license or certificate has been revoked or suspended by another state or jurisdiction;
   5. If a license for an applicant has been revoked or suspended by any state, documentation that includes:
      a. The date of the revocation or suspension,
      b. The state or jurisdiction of the revocation or suspension, and
      c. An explanation of the revocation or suspension;
   6. If an applicant is currently ineligible for licensing in any state because of a license revocation or suspension, documentation that includes:
      a. The date of the ineligibility for licensing,
      b. The state or jurisdiction of the ineligibility for licensing, and
      c. An explanation of the ineligibility for licensing;
   7. If an applicant has been disciplined by any state, territory or district, in this country for an act upon the applicant’s hearing aid dispenser license, documentation that includes:
      a. The date of the disciplinary action,
      b. The state or jurisdiction of the disciplinary action, and
      c. An explanation of the disciplinary action, and
      d. Any other applicable documents, including a legal order or settlement agreement; and
   8. A nonrefundable application fee specified in R9-16-316.

B. The Department shall review an application and documentation for approval according to R9-16-314 and Table 3.1.

Historical Note
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A. An applicant for initial licensure shall submit an application to the Department that includes:
   1. The information and documents required in R9-16-303;
   2. Documentation of passing the:
      a. Written hearing aid dispenser examination, and
      b. Practical examination; and
   3. The fees specified in R9-16-316.

B. In addition to complying with subsections (A)(1) and (A)(3), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:
   1. The name of each state that issued the applicant a current hearing aid dispenser license, including:
      a. The license number of each current hearing aid dispenser license, and
      b. The date each current hearing aid dispenser license was issued;
   2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
   3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
      a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
      b. Has met minimum education requirements according to A.R.S. § 36-1923(A);
      c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
      d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.

C. An initial hearing aid dispenser license is valid for two years from the date of issue for licensure by examination or licensure by reciprocity.

D. If the Department does not issue an initial hearing aid dispenser license to an applicant, the Department shall return the license fee to the applicant.

Historical Note

R9-16-305. Requirements for an Initial Temporary Hearing Aid Dispenser License
A. In addition to complying with R9-16-303, an applicant for a temporary hearing aid dispenser license shall submit to the Department:
   1. The sponsor’s:
      a. Name,
      b. Business address,
      c. Business telephone number, and
      d. Arizona hearing aid dispenser license number.
   2. A statement signed by the sponsor that the sponsor is a licensed hearing aid dispenser who agrees to train, supervise, and be responsible for the applicant’s hearing aid dispenser practice according to A.R.S. § 36-1905.
   3. May choose to:
      a. Complete the two-year test period issued to the applicant with a previous temporary license, or
      b. Restart the two-year test period on the date the Department approves the hearing aid dispenser’s temporary license in subsection (E)(2); and
   4. If the applicant chooses to restart the two-year test period in subsection (3)(b), the previous test result obtained will not apply.

F. An initial hearing aid dispenser license is valid for 12 months from the date of issue for a temporary license or in compliance with A.R.S. § 36-1926(D).

Historical Note
Section repealed, new Section adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-306. Application for Examination
A. In addition to complying with R9-16-303, an applicant for initial licensure by examination shall submit an application to the Department that includes:
   1. Information and documentation required in R9-16-303, and
   2. The fee in R9-16-316.
B. If the Department approves the application, the Department shall notify the applicant of approval to take the written hearing aid dispenser examination as specified in R9-16-302.
C. If the Department approves an application, the applicant shall not practice fitting and dispensing hearing aids without a license issued by the Department.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-307. Initial Application for a Business Hearing Aid Dispenser License
A. An applicant for a business hearing aid dispenser license shall submit to the Department:
   1. An application in a Department-provided format that contains:
A licensee, except for a temporary hearing aid dispenser, shall

R9-16-308. License Renewal
A. A licensee, except for a temporary hearing aid dispenser, shall submit a renewal application in a Department-provided format that contains:
   1. For an individual licensed as a hearing aid dispenser:
      a. The licensee’s name, home address, telephone number, and e-mail address;
      b. The licensee’s current employment, if applicable, including:
         i. The employer’s name,
         ii. The licensee’s position,
         iii. Dates of employment,
         iv. The address of the employer,
         v. The supervisor’s name,
         vi. The supervisor’s email address, and
   2. An application and license fee specified in R9-16-316.
B. A business organization with more than one location shall submit a duplicate license fee for each additional location according to R9-16-315 and R9-16-316.
C. The Department shall review an application for an initial business hearing aid dispenser license according to R9-16-314 and Table 3.1.
D. A business organization licensed according to this Article shall comply with A.R.S. § 36-1910.
E. An initial license issued to a business organization according to this Section is valid for two years from the date of issue.

Historical Note

R9-16-309. A licensee whose license is nonrenewable, according to subsection (E), and is within one year after the expiration date of the previous license issued by the Department.
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F. If allowed in R9-16-303, a temporary hearing aid dispenser shall submit at least 30 calendar days before the expiration date on the license, a renewal application to the Department in a Department-provided format that contains:
   1. The information in R9-16-303(A);
   2. The applicant’s sponsor’s:
      a. Name,
      b. Business address,
      c. Business telephone number, and
      d. Arizona hearing aid dispenser license number;
   3. A statement signed by the sponsor that the sponsor is a licensed hearing aid dispenser who agrees to train, supervise, and be responsible for the applicant’s hearing aid dispenser practice according to A.R.S. § 36-1905; and
   4. A license renewal fee specified in R9-16-316.

G. A renewal license issued to a licensee according to subsection (F) is valid for one year after the expiration date of the previous license issued by the Department.

H. The Department shall review a renewal application according to R9-16-314 and Table 3.1.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-309. Continuing Education
A. Twenty-four months prior to submitting a renewal application, a licensee shall complete 24 continuing education hours that includes no more than eight continuing education hours provided by a single manufacturer of hearing aids.

B. Continuing education shall:
   1. Directly relate to the practice of fitting and dispensing hearing aids;
   2. Have educational objectives that exceed an introductory level of knowledge of fitting and dispensing hearing aids; and
   3. Consist of courses that include advances within the last five years in:
      a. Procedures in the selection and fitting of hearing aids,
      b. Pre- and post-fitting management of clients,
      c. Instrument circuitry and acoustic performance data,
      d. Ear mold design and modification contributing to improved client performance,
      e. Audiometric equipment or testing techniques that demonstrate an improved ability to identify and evaluate hearing loss,
      f. Auditory rehabilitation,
      g. Ethics,
      h. Federal and state statutes or rules, or
      i. Assistive listening devices.

C. A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):
   1. Hearing Healthcare Providers of Arizona,
   2. Arizona Speech-Language-Hearing Association,
   3. American Speech-Language-Hearing Association,
   4. International Hearing Society,
   5. International Institute for Hearing Instrument Studies,
   6. American Auditory Society,
   7. American Academy of Audiology,
   8. Academy of Doctors of Audiology,
   9. Arizona Society of Otolaryngology, Head and Neck Surgery,
   10. American Academy of Otolaryngology-Head and Neck Surgery, or
   11. An organization determined by the Department to be consistent with an organization in subsection (B)(1) through (10).

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-310. Sponsors
A. A sponsor shall:
   1. Provide to a temporary hearing aid dispenser for on-site training and supervision that:
      a. Consists of coordinating, directing, watching, inspecting, and evaluating the fitting and dispensing activities of the temporary hearing aid dispenser; and
      b. Directly relates to the type of training and education needed to pass the licensing examination required in A.R.S. § 36-1924;
   2. Maintain a training record that:
      a. Is signed by the temporary hearing aid dispenser;
      b. Has the date, time, and content of the training and supervision provided to the temporary hearing aid dispenser, as required in subsection (A)(1); and
      c. Is available for inspection by the Department for at least 12 months after the end of the sponsorship agreement; and
   3. Not provide sponsorship to more than two temporary hearing aid dispenser licensees at one time.

B. When a sponsor terminates a sponsorship agreement with a temporary hearing aid dispenser, the sponsor shall:
   1. Provide to the temporary hearing aid dispenser a:
      a. Written notice indicating termination of the sponsorship agreement, and
      b. Copy of the hearing aid dispenser’s records in subsection (A)(2); and
   2. Provide to the Department documentation of the notice required in subsection (B)(1)(a).

Historical Note

R9-16-311. Responsibilities of a Hearing Aid Dispenser
A. A hearing aid dispenser licensed shall:
   1. Upon licensure, notify the Department in writing of the address where the hearing aid dispenser practices the fitting and dispensing of hearing aids;
   2. Conspicuously post the license received in the hearing aid dispenser’s office or place of business;
   3. Except as specified in subsections (A)(4) or (A)(5), conduct audiometric tests before selecting a hearing aid for a client that provides detailed information about the client’s hearing loss, including:
      a. Type, degree, and configuration of hearing loss;
b. Ability, as measured by the percentage of words the client is able to repeat correctly, to discriminate speech; and

c. The client’s most comfortable and uncomfortable loudness levels in decibels;

4. Have the option to conduct audiometric testing required in subsection (A)(3) before selling a client a hearing aid if the client provides to the dispenser the information required in subsection (A)(3) from a licensed professional and the information was:
   a. Obtained within the previous 12 months for an adult, or
   b. Within the previous six months for an individual under the age of 18;

5. Have the option to conduct audiometric testing required in subsection (A)(3) if the tests cannot be performed on the client due to:
   a. The client’s young age, or
   b. A physical or mental disability;

6. Evaluate the performance characteristics of the hearing aid as it functions on the client’s ear for the purpose of assessing the degree of audibility provided by the device and benefit to the client;

7. Provide a bill of sale to a client according to A.R.S. § 36-1909(A) that contains:
   a. Information required in A.R.S. § 36-1909;
   b. A complete description of:
      i. Warranty information, and
      ii. The conditions of any offer of a trial period with a money back guarantee or partial refund; and
   c. The client’s signature and date of signature; and

8. Not:
   a. Practice without a license according to A.R.S. § 36-1907,
   b. Commit unlawful acts according to A.R.S. § 36-1936, or
   c. Commit actions described in A.R.S. § 36-1934(A).

B. The trial period described in subsection (A)(7)(b)(ii) shall not include any time that the hearing aid is in the possession of the hearing aid dispenser or the manufacturer of the hearing aid.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-313. Enforcement
A. The Department may, as applicable:
   1. Deny, revoke, or suspend a license under A.R.S. § 36-1934,
   2. Request an injunction under A.R.S. § 36-1937, or
   3. Assess a civil money penalty under A.R.S. § 36-1939.

B. In determining which disciplinary action specified in subsection (A), the Department shall consider:
   1. The type of violation,
   2. The severity of the violation,
   3. The danger to the public health and safety,
   4. The number of violations,
   5. The number of clients affected by the violations,
   6. The degree of harm to the consumer,
   7. A pattern of noncompliance, and
   8. Any mitigating or aggravating circumstances.

C. A licensee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-314. Time-frames
A. For each type of license issued by the Department under this Article, Table 6.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
   1. An applicant or licensee and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
   2. The extension of the substantive review time-frame and overall time-frame may not exceed 25% of the overall time-frame.
For each type of license issued by the Department under this Article, Table 6.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).

1. The administrative completeness review time-frame begins on the date the Department receives an application required in this Article.

2. Except as provided in subsection (B)(3), the Department shall provide written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
   a. If an application and required documentation is not complete, the notice of deficiencies shall list each deficiency and the information or documentation needed to complete the application.
   b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
   c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application withdrawn.

3. If the Department issues a license during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.

For each type of license issued by the Department under this Article, Table 6.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date the Department sends a written notice to the applicant within the administrative completeness review time-frame.

1. Within the substantive review time-frame, the Department shall provide written notice to the applicant that the Department approved or denied the application.

2. During the substantive review time-frame:
   a. The Department may make one comprehensive written request for additional information or documentation; and
   b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information of documentation.

3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.

4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the license.

D. An applicant who is denied a license may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

Historical Note
Adopted effective June 25, 1993 (Supp. 93-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 3.1. Time-frames (in calendar days)

<table>
<thead>
<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-frame</th>
<th>Administrative Completeness Review Time-frame</th>
<th>Time to Respond to Notice of Deficiency</th>
<th>Substantive Review Time-frame</th>
<th>Time to Respond to Comprehensive Written Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Application for a Hearing Aid Dispenser</td>
<td>A.R.S. §§ 36-1904, 36-1923</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Initial Application for a Business Organization</td>
<td>A.R.S. § 36-1910</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>License Renewal</td>
<td>A.R.S. § 36-1904</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

Historical Note
Table 3.1 renumbered from Table 1 and amended by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Table 3.1 repealed; new Table 3.1 made and recodified under R9-16-314 by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-315. Change Affecting a License or a Licensee; Request for Duplicate License
A. A hearing aid dispenser licensee or temporary hearing aid dispenser licensee shall submit a written notice to the Department in writing within 30 calendar days after the effective date of a change in:
   1. The licensee’s home address or e-mail address, including the new home address or e-mail address;
   2. The licensee’s name, including a copy of one of the following with the licensee’s new name:
      a. Marriage certificate,
      b. Divorce decree, or
      c. Other legal document establishing the licensee’s new name; or
   3. The place or places where the licensee engages in the practice of hearing aid dispensing, including the address or addresses of the place or places where the licensee engages in the practice of hearing aid dispensing.

B. A licensee may obtain a duplicate license by submitting to the Department a request for a duplicate license in a Department-provided format that includes:
   1. The licensee’s name and address,
   2. The licensee’s license number and expiration date,
   3. The licensee’s signature and date of signature, and
   4. A duplicate license fee specified in R9-16-316.
C. A business hearing aid dispenser licensee shall submit a written notice to the Department within 30 calendar days after the licensee:
1. Has a change in the information provided in R9-16-307(A)(1)(b).
2. Closes a location specified in R9-16-307(A)(1)(b) and (c), including the location address.
3. Begins operating at new location, not specified in R9-16-307(A)(1)(c), including the new location address.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 2688, effective June 7, 2002 (Supp. 02-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

Table 1. Renumbered

Historical Note
Table 1 made by final rulemaking at 8 A.A.R. 2688, effective June 7, 2002 (Supp. 02-2). Table 1 renumbered to Table 3.1 by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2).

R9-16-316. Fees
A. An applicant shall submit to the Department the following fee for:
1. A nonrefundable initial application, $100;
2. An initial license for a regular or business hearing aid dispenser, $200;
3. A renewal application for temporary hearing aid dispenser license, $100.
4. A regular or business hearing aid dispenser licensee for a renewal license, $200.
B. If a renewal application is submitted within 30 calendar days after the license expiration date, a licensee shall submit with the renewal application a $25 late fee.
C. The fee for a duplicate license is $25.
D. An applicant, who is not a business organization, for initial licensure is not required to submit the applicable fee in subsection (A) if the applicant, as part of the applicable application in R9-16-303 or R9-16-306, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 2063, effective July 3, 2004 (Supp. 04-2). Historical note corrected to reflect the rulemaking action on file and effective with the 04-2 supplement (Supp. 05-2). Section repealed; new Section made by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2). Section repealed; new Section made by final expedited rulemaking at 26 A.A.R. 835, with an immediate effective date of April 8, 2020 (Supp. 20-2).

R9-16-317. Repealed

Historical Note

ARTICLE 4. REGISTRATION OF ENVIRONMENTAL HEALTH SANITARIANS

R9-16-401. Definitions
The following definitions apply in this Article, unless otherwise specified:
1. “Accredited” means that an educational institution is recognized by the U.S. Department of Education as providing standards necessary to meet acceptable levels of quality for its graduates to gain admission to other reputable institutions of higher learning or to achieve credentials for professional practice.
2. “Administrative completeness review time-frame” has the same meaning as in A.R.S. § 41-1072.
3. “Applicant” means an individual who submits an application packet or renewal application packet for registration as an environmental health sanitarian.
4. “Application packet” means the information, documents, and fees required by the Department to:
   a. Determine eligibility to take a sanitarian examination,
   b. Be registered as an environmental health sanitarian.
5. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run and including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.
6. “Continuing education” means a course that provides instruction and training that is designed to develop or improve a registered environmental health sanitarian’s professional competence in disciplines directly related to the practice of a registered environmental health sanitarian.
7. “Continuing education hour” means 50 to 60 minutes of continuous course work.
8. “Course” means a workshop, seminar, lecture, conference, or other learning program activities as approved by the Department.
10. “Environmental health” means the science and practice of preventing human injury and illness and promoting well-being by identifying sources that produce potential hazardous physical, chemical, and biological agents in air, water, soil, food, and other conditions; and eliminating or minimizing exposure to the sources that adversely affect or may adversely affect human health.
11. “Environmental health sanitarian aide” means an individual who performs and assists with environmental health services as described and under the supervision of an individual in R9-16-403.
12. “Hazardous environmental agent” means a material, whether liquid, solid, gas, or sludge, that contains properties that make the material potentially harmful to public health or the environment.
13. “Immediate family member” means an individual related by birth, marriage, or adoption.
14. “License or licensed” means a permit, certificate, or similar form of approval issued by a state agency according to state law that an individual may practice in the profession indicated by the approval.
15. “Natural science” means a branch of science that deals with the physical world, including life, physical, and health sciences.
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16. “Overall time-frame” has the same meaning as in A.R.S. § 41-1072.
17. “Practice of a registered environmental health sanitarian” means acting under the authority of R9-16-402.
18. “Registered environmental health sanitarian” means the same as a “registered sanitarian” in A.R.S. § 36-136.01.
19. “Renewal application packet” means the information, documents, and fees required by the Department to apply for a renewal registration as an environmental health sanitarian.
20. “Sanitarian examination” means a test that consists of questions related to environmental health including natural sciences, facility and system inspections, investigations, compliance, responding to emergencies, and promoting environmental public health awareness.
21. “Semester credit” means one earned academic unit of study or equivalent, with a grade of “C” or better, at an accredited college or university by:
   a. Attending a 50 to 60 minute class session each calendar week for at least 16 weeks, or
   b. Completing practical work for a class as determined by the accredited college or university.
22. “Substantive review time-frame” has the same meaning as in A.R.S. § 41-1072.
23. “Supervision” means being responsible for and providing direction to an individual who:
   a. Performs and assists a registered environmental health sanitarian with environmental health services as described in R9-16-403, and
   b. Is employed as an environmental health sanitarian aide in a position directly related to environmental health.
24. “Testing center” means a facility, approved by the Department that provides a proctored computer-based sanitarian examination.

Historical Note


R9-16-403. Requirements for an Environmental Health Sanitarian Aide

A. An environmental health sanitarian aide may perform and assist in any of the following environmental health services:
   1. Inspections related to food establishments, food processing, food distribution, sewage and refuse disposal, water supplies, hotels, motels, campground, swimming pools, and other related public facilities regulated under A.A.C. Title 9, Chapter 8;
   2. Investigations of complaints to ensure compliance with environmental regulations;
   3. Routine samplings of water, sewage, food, and other samples for analysis; or

B. An environmental health sanitarian aide shall:
   1. Have reports reviewed by a registered environmental health sanitarian;
   2. Not approve or disapprove the operation of an establishment under A.A.C. Title 9, Chapter 8; and
   3. Not sign on behalf of a registered environmental health sanitarian.

C. A sanitarian aide, who has completed at least five years of employment as an environmental health sanitarian aide in a position directly related to environmental health, may apply...
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for registration as an environmental health sanitarian according to R9-16-405.

D. An individual who provides supervision to an environmental health sanitarian aide shall:
   1. Ensure that the number of hours and type of supervision in providing environmental health services is consistent with:
      a. The sanitarian aide’s skills and experience,
      b. The setting where the environmental health services are provided, and
      c. The tasks assigned;
   2. Establish a record for the environmental health sanitarian aide who receives supervision that includes:
      a. The sanitarian aide’s name, address, e-mail address, and telephone number;
      b. A plan indicating the types of skills and the number of hours allocated to the development of each skill that the environmental health sanitarian aide is expected to complete;
      c. Documentation of evaluations provided to the environmental health sanitarian aide during the time supervision was provided; and
      d. Documentation of when supervision began and ended; and
   3. Maintain a sanitarian aide’s record throughout the period that the environmental health sanitarian aide received supervision.

Historical Note

R9-16-404. Continuing Education Requirements; Continuing Education Deferral; and Renewal Extension

A. A registered environmental health sanitarian shall complete 12 continuing education hours during the 12 months prior to December 31 of each calendar year, unless the registered environmental health sanitarian:
   1. Has been a registered environmental health sanitarian for less than 12 months as indicated on the renewal application;
   2. Was prevented from completing continuing education according to subsection (A) due to a personal or immediate family member’s illness during at least six continuous months of the preceding 12 months; or
   3. Was called to active military service.

B. Except for a registered environmental health sanitarian in subsection (A)(1) and (3), by November 1 of each calendar year, a registered environmental health sanitarian may request to defer continuing education by submitting:
   1. A request in a Department-provided format that contains:
      a. The registered environmental health sanitarian’s name, address, e-mail address, and telephone number;
      b. The registered environmental health sanitarian’s registration number;
      c. A statement regarding the registered environmental health sanitarian’s personal or immediate family member’s illness;
      d. Indicate the number of continuing education hours requesting to defer;
      e. An attestation that the Department is authorized to verify all information provided in the continuing education deferral request; and
      f. The registered environmental health sanitarian’s signature, including date of signature;
   2. Documentation that verifies the duration of the registered environmental health sanitarian’s personal or immediate family member’s illness from the physician treating or who treated the registered environmental health sanitarian’s personal or immediate family member’s illness; and
   3. If a registered environmental health sanitarian has completed any continuing education hours, report the completed continuing education hours according to R9-16-406(D)(1)(b).

C. A registered environmental health sanitarian that deferred continuing education in subsection (B) shall obtain:
   1. The deferred continuing education by the end of the subsequent renewal year, and
   2. The continuing education required in subsection (A) for the current renewal year.

D. A registered environmental health sanitarian called to active military service:
   1. Shall submit:
      a. Written notice for renewal extension to the Department that includes:
         i. The registered environmental health sanitarian’s name, address, e-mail address, and telephone number;
         ii. The registered environmental health sanitarian’s registration number;
         iii. A statement stating the reason for the notice of renewal extension; and
         iv. The registered environmental health sanitarian’s signature, including date of signature; and
      b. A copy of the registered environmental health sanitarian’s deployment documentation;
   2. Submits registration as an environmental health sanitarian for the term of service or deployment plus 180 calendar days;
   3. Defers the requirement for completing the continuing education for the term of service or deployment plus 180 calendar days; and
   4. Shall submit a renewal application packet according to R9-16-406 after the term of service or deployment plus 180 calendar days.

E. The Department shall review the request to defer continuing education submitted in subsection (B) for approval according to R9-16-407 and Table 4.1.

F. If the Department denies a registered environmental health sanitarian’s request to defer continuing education, the registered environmental health sanitarian shall submit the required continuing education hours in subsection (A) according to R9-16-406(D)(1)(b).

Historical Note

R9-16-405. Application for Sanitarian Examination and Registration

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A. An individual may apply to take the sanitarian examination for registration as a sanitarian if the individual meets one of the eligibility requirements in R9-16-402(A)(1) through (A)(3).

B. At least seven calendar days before a Sanitarians Council meeting, an applicant for environmental health sanitarian registration shall submit an application packet to the Department containing:

1. The following information in a Department-provided format:
   a. The applicant’s name, address, e-mail address, and telephone number;
   b. If applicable, applicant’s former names;
   c. The applicant’s social security number, required under A.R.S. §§ 25-320 and 25-502;
   d. If applicable, the applicant’s current employment information:
      i. The employer’s name, address, e-mail address, and telephone number;
      ii. The applicant’s position title; and
      iii. The applicant’s employment start date;
   e. If an applicant meets the eligibility requirement in R9-16-402(A)(1), the following for each college or university where the applicant completed semester credits or the equivalent credits from a college or university:
      i. The college or university’s name, address, e-mail address, and telephone number;
      ii. The number of natural science semester credits completed; and
      iii. If applicable, the degree obtained;
   f. If an applicant meets the eligibility requirement in R9-16-402(A)(2), the following for each employer during the five years the applicant was employed as a sanitarian aide:
      i. The employer’s name, address, e-mail address, and telephone number;
      ii. The name, title, e-mail address, and telephone number of a contact individual for the employer;
      iii. The applicant’s position and description of responsibilities; and
      iv. The months and years of employment;
   g. If an applicant meets the eligibility requirement in R9-16-402(A)(3), the following for each active military service assignment during the five years the applicant held a military job position in the field of environmental health:
      i. The military branch name, address, e-mail address, and telephone number;
      ii. The name, title, e-mail address, and telephone number of a contact individual from the military branch;
      iii. The applicant’s military job position and description of responsibilities; and
      iv. The months and years of active military service assignments;
   h. If an applicant meets the eligibility requirement in R9-16-402(A)(4), the following for a sanitarian licensed in another state or jurisdiction:
      i. The state, county, and city that issued the applicant’s current license as a sanitarian;
      ii. The testing organization that administered the sanitarian examination;
      iii. The name of the sanitarian examination;
      iv. The sanitarian examination administration date;
   i. The number of sanitarian examination questions;
   ii. The sanitarian examination score;
   iii. The other eligibility requirement in R9-16-402(A)(1) through (A)(3) met by the applicant; and
   iv. As applicable, the information required in subsection (B)(1)(e), (f), or (g);
   j. Whether the applicant is or has been licensed as a sanitarian in another state or jurisdiction;
   k. Whether the applicant has had an application for licensure as a sanitarian denied in a state or jurisdiction;
   l. If the applicant has had an application for licensure as a sanitarian denied, the:
      i. Reason for denial;
      ii. Date of the denial; and
      iii. Name, address, and telephone number of the licensing agency that denied the applicant’s application;
   m. Whether the applicant has had a license as a sanitarian suspended or revoked by a state or jurisdiction entered into a consent agreement with a state or jurisdiction;
   n. If the applicant has had a license as a sanitarian suspended or revoked or entered into a consent agreement, the:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction, and
      iii. An explanation of the crime of which the applicant was convicted, and
   o. Whether the applicant has been convicted of a felony or a misdemeanor in subsection (B)(1)(o);
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the applicant was convicted, and
   p. Whether the applicant agrees to allow the Department to submit supplemental requests for additional information or documentation in R9-16-407;
   q. Whether the applicant was convicted of a felony or a misdemeanor in subsection (B)(1)(o);
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the applicant was convicted, and
   r. A signature of the applicant’s signature and date of signature;
2. In addition to the application in subsection (B)(1), the following:
   a. A copy of applicant’s Social Security card;
   b. Proof of U.S. citizenship or alien status according to A.R.S. § 41-1080;
   c. If applicable, a copy of an applicant’s sanitarian license issued by another state or jurisdiction;
   d. If an official transcript is issued by a college or university from outside of the United States or its territories, documentation from a third party evaluation service verifying equivalent credits identified in subsection (B)(1)(e);
   e. If applicable, a letter verifying an applicant’s start and end dates of employment for each employer identified in subsection (B)(1)(f);
   f. If applicable, a letter verifying an applicant’s start and end dates of the military job position for each active military service assignment identified in subsection (B)(1)(g);
   g. If applicable, documentation of the completed sanitarian examination, including the sanitarian examination test results, from the testing center or jurisdiction that administered the sanitarian examination required by another state or jurisdiction in subsection (B)(1)(h); and
   h. If applicable, a copy of the official notice from a testing center in subsection (B)(1)(i); and
3. The nonrefundable $25 application fee.
C. If an official transcript documents natural science semester credit hours identified in subsection (B)(1)(e), an applicant shall instruct the college or university to send the official transcript to the Department.
D. The Department shall review an application packet for an applicant to take a sanitarian examination according to R9-16-407 and Table 4.1.
E. The Department shall review a sanitarian examination for an applicant licensed by another state or jurisdiction for approval for the applicant to practice as a registered environmental health sanitarian according to R9-16-407 and Table 4.1.
F. An applicant approved to take a sanitarian examination shall:
   1. Select a testing center,
   2. Take a scheduled sanitarian examination administered by the testing center,
   3. Pass the sanitarian examination with a score of 70% or more and submit a copy of the applicant’s official sanitarian examination test results to the Department.
G. The Department shall review an application packet for approval for an applicant to practice as a registered environmental health sanitarian according to R9-16-407 and Table 4.1.
H. An applicant, who does not submit a copy of official sanitarian examination test results to the Department in subsection (F) within six months after the date that the applicant received the notice of approval to take the sanitarian examination, shall submit a new application packet according to R9-16-405(B).
I. An applicant, who submits a copy of official sanitarian examination test results to the Department in subsection (F) within six months after the date that the applicant received the notice of approval to take the sanitarian examination and does not score 70% or more, shall:
   1. Have 12 months from the date of the approval letter the applicant received from the Department to provide a copy of official sanitarian examination test results in subsection (F); and
   2. Comply with subsection (F)(1) through (F)(3) to retake the sanitarian examination.
A. The overall time-frame begins, for:
1. A sanitarian examination approval, on the date the Department receives an application packet in R9-16-405(A);
2. An environmental health sanitarian registration approval, on the date the Department receives a renewal application packet in R9-16-406.

B. The applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame. The substantive review time-frame and the overall time-frame may not be extended by more than 25% of the overall time-frame.

C. Within the administrative completeness review time-frame in Table 4.1, the Department shall:
1. Provide a notice of administrative completeness to an applicant; or
2. Provide a notice of deficiencies to an applicant, including a list of the missing information or documents.

D. If the Department provides a notice of deficiencies to an applicant:
1. The administrative completeness review time-frame and the overall time-frame are suspended after the date of the notice of deficiencies until the date the Department receives the missing information or documents from the applicant;
2. If the applicant submits the missing information or documents to the Department within the time-frame in Table 4.1, the substantive review time-frame resumes on the date the Department receives the missing information or documents; and
3. If the applicant does not submit the missing information or documents to the Department within the time-frame in Table 4.1, the Department shall consider the application or the request withdrawn.

E. If the Department issues a registration or notice of an approval during the administrative completeness review time-frame, the Department may not issue a separate written notice of administrative completeness.

F. Within the substantive review time-frame specified in Table 4.1, the Department:
1. Shall approve an:
   a. Applicant’s request for registration as an environmental health sanitarian or
   b. Applicant, who did not score 70% or more on the sanitarian examination, to resubmit a sanitarian examination according to R9-16-405(I);
2. Shall deny an applicant’s request for registration as an environmental health sanitarian or
3. May make a written comprehensive request for additional information or documentation; and
4. May make supplemental requests for additional information and documentation if agreed to by the applicant.

G. If the Department provides a written comprehensive request for additional information or documentation or a supplemental request to the applicant:
1. The substantive review time-frame and overall time-frame are suspended from the date of the written comprehensive request until the date the Department receives the information and documentation requested; and
2. The applicant shall submit to the Department the information and documents listed in the written comprehensive request within 15 calendar days after the date of the written comprehensive request or supplemental request.

H. The Department shall issue:
1. An approval to an applicant who submits:

h. Except for a registered environmental health sanitarian in R9-16-404(A), for each continuing education course completed during the previous 12 months, the following:
i. The course title,
ii. A course description,
iii. The name of the individual providing the continuing education course,
iv. The date the continuing education course was completed, and
v. The total number of continuing education hours attended;

i. Whether the applicant has been a registered environmental health sanitarian for less than 12 months according to R9-16-404(A)(1);

j. An attestation that:
i. The applicant affirms that the continuing education courses specified according to subsection (h) are applicable and consistent with the Department’s approved continuing education courses or with the practice of a registered environmental sanitarian described in R9-16-402(C);
ii. The applicant authorizes the Department to verify all information provided in the renewal application packet; and
iii. The information submitted as part of the renewal application packet is true and accurate;

k. The applicant’s signature and date of signature;

l. If applicable, a copy of the approved request to defer continuing education, and

m. The $10 renewal application fee.

E. If a registered environmental health sanitarian does not submit a renewal application packet in subsection (D) by February 15:

1. The registered environmental health sanitarian’s registration expires on February 16; and

2. Before practicing as a registered environmental health sanitarian, a registered environmental health sanitarian whose environmental health sanitarian registration expired shall submit a new application packet according to R9-16-405.

F. The Department shall review the renewal application packet for approval of registration as an environmental health sanitarian according to R9-16-407 and Table 4.1.

Historical Note
### R9-16-409. Denial, Suspension, or Revocation

A. The Department may deny an application packet for approval for registration or renewal of registration if the Department determines that an applicant:

1. Intentionally provided false information or documents in an application packet or renewal application packet;
2. Had an application for a license related to the practice of a registered environmental health sanitarian denied by a state or jurisdiction; or
3. Had a license related to the practice of a registered environmental health sanitarian suspended or revoked by a state or jurisdiction;
4. Was convicted of a felony;
5. Had a license related to the practice of a registered environmental health sanitarian suspended or revoked by a state or jurisdiction or entered into a consent agreement with a state or jurisdiction; or
6. Did not respond to a request or supplemental request for additional information or documentation; or
7. Did not respond to an application or renewal application packet; or
8. Denied by a state or jurisdiction.

B. The Department may suspend or revoke a registered environmental health sanitarian’s registration if the Department determines that a registered environmental health sanitarian:

#### Table 4.1. Time-frames (in calendar days)

<table>
<thead>
<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-frame</th>
<th>Administrative Completeness Review Time-frame</th>
<th>Time to Respond to Deficiency Notice</th>
<th>Substantive Review Time-frame</th>
<th>Time to Respond to Written Comprehensive Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanitarian Examination (R9-16-405)</td>
<td>A.R.S. § 36-136.01(B)</td>
<td>150</td>
<td>30</td>
<td>30</td>
<td>120</td>
<td>15</td>
</tr>
<tr>
<td>Initial Registration (R9-16-405)</td>
<td>A.R.S. § 36-136.01(B)</td>
<td>40</td>
<td>10</td>
<td>15</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>Registration by Reciprocity (R9-16-405)</td>
<td>A.R.S. § 36-136.01(C)</td>
<td>150</td>
<td>30</td>
<td>30</td>
<td>120</td>
<td>15</td>
</tr>
<tr>
<td>Deferred Continuing Education (R9-16-404)</td>
<td>A.R.S. § 36-136.01(E)</td>
<td>45</td>
<td>30</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Renewal Registration (R9-16-406)</td>
<td>A.R.S. § 36-136.01(D)</td>
<td>75</td>
<td>60</td>
<td>15</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

**Historical Note**

Table 4.1 Time-frames made by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4). Amended by final rulemaking at 26 A.A.R. 1875, with an immediate effective date of September 2, 2020 (Supp. 20-3).
CHAPTER 16. DEPARTMENT OF HEALTH SERVICES - OCCUPATIONAL LICENSING

1. Assisted an individual who is not a registered environmental health sanitarian to circumvent the requirements in this Article;

2. Allowed an individual who is not a registered environmental health sanitarian to use the registered environmental health sanitarian’s registration;

3. Falsified records to interfere with or obstruct an investigation or regulatory process of the Department or a political subdivision; or

4. Failed to comply with any of the requirements in A.R.S. § 36-136.01 or this Article.

C. In determining whether to suspend or revoke a registered environmental health sanitarian’s registration, the Department shall consider the threat to public health based on:

1. Whether there is repeated non-compliance with statutes or rules,
2. Type of non-compliance,
3. Severity of non-compliance, and
4. Number of non-compliance actions.

D. The Department’s notice of suspension or revocation to the applicant or registered environmental health sanitarian shall comply with A.R.S. Title 41, Chapter 6, Article 10.

Historical Note

R9-16-410. Repealed


R9-16-411. Repealed


R9-16-412. Repealed

Adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-413. Repealed

Adopted effective April 12, 1985 (Supp. 85-2). Section repealed by final rulemaking at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2).

R9-16-414. Expired

Former Section R9-16-411 renumbered as Section R9-16-414 effective April 12, 1985 (Supp. 85-2). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective September 30, 2001 (Supp. 01-4).

Table 1. Repealed

Historical Note

Table 1. Time-frames made by final rulemaking under new Section R9-16-405 at 8 A.A.R. 2444, effective May 16, 2002 (Supp. 02-2). Table 1. Time-frames following Section R9-16-405 renumbered below Section R9-16-407 and amended by final rulemaking at 10 A.A.R. 3004, effective September 11, 2004 (Supp. 04-3). Table 1. Time-frames repealed by final rulemaking at 23 A.A.R. 3038, effective October 5, 2017 (Supp. 17-4).

ARTICLE 5. LICENSING SPEECH-LANGUAGE PATHOLOGIST ASSISTANTS

R9-16-501. Definitions

In addition to the definitions in A.R.S. § 36-1901, the following definitions apply in this Article unless otherwise specified:

1. “Accredited” means approved by the:
   a. New England Commission of Higher Education,
   b. Middle States Commission on Higher Education,
   c. Higher Learning Commission,
   d. Northwest Commission on Colleges and Universities,
   e. Southern Association of Colleges and Schools Commission on Colleges, or
   f. WASC Senior College and University Commission.

2. “Applicant” means an individual who submits a license application and required documentation for approval to practice as a speech-language pathologist assistant.

3. “Calendar day” means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.

4. “Continuing education” means a course that provides instruction and training that is designed to develop or improve a licensee’s professional competence in disciplines that directly relate to the licensee’s scope of practice.

5. “Course” means a workshop, seminar, lecture, conference, or class.

6. “Documentation” means information in written, photographic, electronic, or other permanent form.

7. “General education” means instruction that includes:
   a. Oral communication,
   b. Written communication,
   c. Mathematics,
   d. Computer instruction,
   e. Social sciences, and
   f. Natural sciences.

8. “Observation” means to witness:
   a. The provision of speech-language pathology services to a client.
   b. A demonstration of how to provide speech-language pathology services to a client.

9. “Semester credit hour” means one earned academic unit of study completed, at an accredited college or university, by:
   a. Attending a 50 to 60 minute class session each calendar week for at least 16 weeks, or
   b. Completing practical work for a course as determined by the accredited college or university.
10. “Speech-language pathologist” means an individual who is licensed under A.R.S. § 36-1940.01.
11. “Speech-language pathology technical course work” means a curriculum that provides knowledge to develop core skills and assume job responsibilities, including:
   a. Language acquisition,
   b. Speech development,
   c. Communication disorders,
   d. Articulation and phonology, and
   e. Intervention techniques for speech and language disorders.
12. “Supervision” means instruction and monitoring provided by a licensed speech-language pathologist as required in A.R.S. § 36-1940.04(E) and (F) to an individual training to become a speech-language pathologist assistant.

**Historical Note**

**R9-16-502. Initial Application**
A. An applicant for licensure shall submit to the Department:
   1. An application in a Department-provided format that contains:
      a. The applicant’s name, home address, telephone number, and e-mail address;
      b. The applicant’s Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
      c. If applicable, the name of the applicant’s employer and the employer’s business address and telephone number;
      d. Whether the applicant has ever been convicted of a felony or of a misdemeanor in this state or another state;
      e. If the applicant has been convicted of a felony or a misdemeanor:
         i. The date of the conviction,
         ii. The state or jurisdiction of the conviction,
         iii. An explanation of the crime of which the applicant was convicted, and
         iv. The disposition of the case;
      f. Whether the applicant has had a license revoked or suspended by any state;
      g. Whether the applicant is currently ineligible for licensure in any state because of a prior license revocation or suspension;
      h. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-506;
      i. An attestation that the information submitted is true and accurate; and
      j. The applicant’s signature and date of signature;
   2. If applicable, a list of all states and countries in which the applicant is or has been licensed as a speech-language pathologist assistant;
   3. If a license for an applicant has been revoked or suspended by any state, documentation that includes:
      a. The date of the revocation or suspension,
      b. The state or jurisdiction of the revocation or suspension, and
      c. An explanation of the revocation or suspension;
   4. If the applicant is currently ineligible for licensure in any state because of a prior license revocation or suspension, documentation that includes:
      a. The date of the ineligibility for licensure,
      b. The state or jurisdiction of the ineligibility for licensure, and
      c. An explanation of the ineligibility for licensure;
   5. Documentation of the applicant’s citizenship or alien status that complies with A.R.S. § 41-1080.
   6. A transcript or equivalent documentation issued to the applicant from an accredited college or university, showing completion of at least 60 semester credit hours of general education and speech-language pathology technical course work specified in A.R.S. § 36.1940.04(A) that requires:
      a. No less than 20 semester credit hours of general education, and
      b. No less than 20 semester credit hours of speech-language pathology technical course work;
   7. Documentation, signed by a licensed speech-language pathologist as required in A.R.S. §36-1940.04 who provided supervision to the applicant, confirming the applicant’s completion of at least 100 hours of clinical interaction that did not include observation; and
   8. The application and licensing fees specified in R9-16-508.

B. In addition to complying with subsection (A)(1) through (5), an applicant that may be eligible for licensure under A.R.S. § 36-1922 shall submit documentation to the Department that includes:
   1. The name of each state that issued the applicant a current speech-language pathologist assistant, including:
      a. The license number of each current speech-language pathologist assistant license, and
      b. The date each current speech-language pathologist assistant license was issued;
   2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
   3. For each state named in subsection (B)(1), a statement, signed and dated by the applicant, attesting that the applicant:
      a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which licensure is being requested;
      b. Has met minimum education requirements according to A.R.S. § 36-1940.04;
      c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
      d. Does not have a complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct.

C. A regular license is valid for two years from the date of issue.
D. The Department shall review the application and required documentation for an initial license to practice as a speech-language pathologist assistant according to R9-16-506 and Table 5.1.
E. If the Department does not issue an initial license to an applicant, the Department shall refund the license fee to the applicant.

**Historical Note**
New Section made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4).
A. Before the expiration date of a speech-language pathologist assistant license, a licensee shall submit to the Department:

1. An application in a Department-provided format for renewal of a speech-language pathologist assistant license that contains:
   a. The licensee’s name, home address, telephone number, and e-mail address;
   b. The licensee’s current employment, if applicable, including:
      i. The employer’s name,
      ii. The licensee’s position,
      iii. Dates of employment,
      iv. The address of the employer,
      v. The supervisor’s name,
      vi. The supervisor’s e-mail address, and
      vii. The supervisor’s telephone number;
   c. If applicable, the name of the licensee’s supervising speech-language pathologist;
   d. The licensee’s license number and date of expiration;
   e. Since the previous license application, whether the licensee has been convicted of a felony or a misdemeanor involving moral turpitude in this or another state;
   f. If the licensee has been convicted of a felony or a misdemeanor:
      i. The date of the conviction,
      ii. The state or jurisdiction of the conviction,
      iii. An explanation of the crime of which the licensee was convicted, and
      iv. The disposition of the case;
   g. Whether the licensee has had a license revoked or suspended by any state within the previous two years;
   h. Whether the licensee is currently ineligible for licensure in any state because of a prior license revocation or suspension;
   i. Whether the licensee agrees to allow the Department to submit supplemental requests for information under R9-16-506;
   j. An attestation that the licensee has completed continuing education required under A.R.S. 36-1904 and this Article and documentation of completion is available upon request;
   k. An attestation that the information required as part of the renewal application is true and accurate; and
   l. The licensee’s signature and date of signature.
2. If a license for a licensee has been revoked or suspended by any state within the previous two years, documentation that includes:
   a. The date of the revocation or suspension,
   b. The state or jurisdiction of the revocation or suspension, and
   c. An explanation of the revocation or suspension;
3. If the licensee is currently ineligible for licensure in any state because of a prior license revocation or suspension, documentation that includes:
   a. The date of the ineligibility for licensure,
   b. The state or jurisdiction of the ineligibility for licensure, and
   c. An explanation of the ineligibility for licensure;

B. According to A.R.S. § 36-1904, the Department shall allow a speech-language pathologist assistant to renew a license within 30 calendar days after the expiration date of the license by submitting to the Department:

1. The renewal application, including documentation required in subsection (A), and
2. Fees specified in R9-16-508.

C. An individual who does not submit a renewal application, documentation; and fees required in subsection (A) or (B), shall reapply for an initial license according to R9-16-502.

### Historical Note


### R9-16-504. Continuing Education

A. Twenty-four months prior to submitting a renewal application, a licensee shall complete continuing education.

B. Continuing education shall:

1. Directly relate to the practice of speech-language pathology;
2. Have educational objectives that exceed an introductory level of knowledge of speech-language pathology; and
3. Consist of courses that include advances within the last five years in:
   a. Practice of speech-language pathology,
   b. Auditory rehabilitation,
   c. Ethics, or
   d. Federal and state statutes or rules.

C. A continuing education course developed, endorsed, or sponsored by one of the following meets the requirements in subsection (B):

1. Hearing Healthcare Providers of Arizona,
2. Arizona Speech-Language-Hearing Association,
3. American Speech-Language-Hearing Association,
4. International Hearing Society,
5. International Institute for Hearing Instrument Studies,
6. American Auditory Society,
7. American Academy of Audiology,
8. Academy of Doctors of Audiology,
9. Arizona Medical Association,
10. American Academy of Otolaryngology-Head and Neck Surgery, or
11. An organization determined by the Department to be consistent with an organization in subsection (C)(1) through (10).

D. A speech-language pathologist assistant shall comply with the requirements in A.R.S. § 36-1904.

### Historical Note

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April 8, 2020 (Supp. 20-2).

R9-16-505. Enforcement
A. The Department may, as applicable:
   1. Deny, revoke, or suspend an speech-language pathologist assistant license under A.R.S. § 36-1934;
   2. Request an injunction under A.R.S. § 36-1937; or
   3. Assess a civil money penalty under A.R.S. § 36-1939.
B. In determining which disciplinary action specified in subsec (A) is appropriate, the Department shall consider:
   1. The type of violation,
   2. The severity of the violation,
   3. The danger to public health and safety,
   4. The number of violations,
   5. The number of clients affected by the violations,
   6. The degree of harm to a client,
   7. A pattern of noncompliance, and
   8. Any mitigating or aggravating circumstances.

Historical Note

Table 1. Renumbered

Historical Note
New Table 1 made by final rulemaking at 15 A.A.R. 2132, effective January 30, 2010 (Supp. 09-4). Table 1 renumbered to Table 5.1 by exempt rulemaking at 20 A.A.R. 1998, effective July 1, 2014 (Supp. 14-2).

R9-16-506. Time-frames
A. For each type of license issued by the Department under this Article, Table 5.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).
   1. An applicant or licensee and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
   2. The extension of the substantive review time-frame and the overall time-frame may not exceed 25% of the overall time-frame.
B. For each type of license issued by the Department under this Article, Table 5.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).
   1. The administrative completeness review time-frame begins on the date the Department receives an application and required documentation required in this Article.
   2. Except as provided in subsection (B)(3), the Department shall provide a written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.

Historical Note

Table 5.1. Time-frames (in calendar days)

<table>
<thead>
<tr>
<th>Type of Approval</th>
<th>Statutory Authority</th>
<th>Overall Time-Frame</th>
<th>Administrative Completeness Review Time-Frame</th>
<th>Time to Respond to Notice of Deficiency</th>
<th>Substantive Review Time-Frame</th>
<th>Time to Respond to Comprehensive Written Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial License (R9-16-502)</td>
<td>A.R.S. §§ 36-1904 and 36-1940.04</td>
<td>60</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>
A. A licensee shall submit a notice to the Department in writing requesting a duplicate license.

B. An applicant shall submit to the Department a $200 license fee.

C. An applicant shall submit to the Department the following:
   1. The licensee’s name and address,
   2. The licensee’s license number and expiration date,
   3. The licensee’s signature and date of signature, and
   4. A duplicate license fee specified in R9-16-508.

R9-16-507. Changes Affecting a License or a Licensee; Request for a Duplicate License

A. A licensee shall submit a notice to the Department in writing within 30 calendar days after the effective date of a change in:
   1. The licensee’s home address or e-mail address, including the new home address or e-mail address;
   2. The licensee’s name, including one of the following with the licensee’s new name:
      a. Marriage certificate,
      b. Divorce decree, or
      c. Other legal document establishing the licensee’s new name; or
   3. The place or places, including address or addresses, where the licensee engages in the practice of speech-language pathology.

B. A licensee may obtain a duplicate license by submitting to the Department a written request for a duplicate license in a Department-provided format that contains:
   1. The licensee’s name and address,
   2. The licensee’s license number and expiration date,
   3. The licensee’s signature and date of signature, and
   4. A duplicate license fee specified in R9-16-508.

R9-16-508. Fees

A. An applicant shall submit to the Department the following fees:
   1. An initial nonrefundable application fee, $100; and
   2. An initial license fee, $200.

B. An applicant shall submit to the Department a $200 license fee for renewal.

C. If an applicant submits a renewal license application specified in subsection (B) within 30 calendar days after the license expiration date, the applicant shall submit with the renewal license application a $25 late fee.

D. An applicant for initial licensure is not required to submit the applicable fee in subsection (A), if the applicant submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 36-1904.

E. The fee for a duplicate license is $25.

Historical Note


ARTICLE 6. RADIATION TECHNOLOGISTS

R9-16-601. Definitions

In addition to the definitions in A.R.S. § 32-2801, the following definitions apply in this Article unless otherwise specified:

1. “Applicant” means:
   a. An individual who submits an application packet, or
   b. A person who submits a request for approval of a radiation technologist training program.

2. “Application packet” means the information, documents, and fees required by the Department for a certificate or permit.

3. “ARRT” means the American Registry of Radiologic Technologists.

4. “Authorized user” means the same as in A.A.C. R9-7-102.

5. “Calendar day” means each day, not including the day of the act, event, or default, from which a designated period of time beings to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide furlough day, or legal holiday.


7. “Certification” means the issuing of a certificate.

8. “Chest radiography” means radiography performed to visualize the heart and lungs only.

9. “Continuing education” means a course or learning activity that provides instruction and training designed to develop or improve the professional competence of a certificate holder related to the certificate holder’s scope of practice.

10. “Contrast media” means material intentionally administered to a human body to define a part or parts of the human body that are not normally radiographically visible.

11. “Department-approved educational program” means a curriculum of courses and learning activities that is accredited by a nationally recognized accreditation body or granted approval through the Department.

12. “Department-approved examination” means a test administered through ARRT, NMTCB, ISCD, or CBRPA.

13. “Extremity” means the same as in A.A.C. R9-7-102.

14. “Fluoroscopy” means the use of radiography to directly visualize internal structures of the human body, the motion of internal structures, and fluids in real time, or near real-time, to aid in the treatment or diagnosis of disease or the performance of other medical procedures.

15. “ISCD” means the International Society for Clinical Densitometry.

16. “Nationally recognized accreditation body” means ARRT, NMTCB, ISCD, or CBRPA.

17. “NMTCB” means the Nuclear Medicine Technology Certification Board.

18. “Radiograph” means the record of an image, representing anatomical details of a part of a human body examined through the use of ionizing radiation, formed by the dif-
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ferential absorption of ionizing radiation within the part of the human body.
20. “Radiopharmaceutical agent” means a radionuclide or radionuclide compound designed and prepared for administration to human beings.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-602. Training Programs
A. The Department shall maintain a list of Department-approved educational programs according to A.R.S. § 32-2804 on the Department’s website at https://www.azdhs.gov/licensing/special/index.php#mrt-provider-info.
B. An applicant may request Department approval of a curriculum of courses and learning activities as a training program by submitting an application packet that contains:
   1. An application, in a Department-provided format, that includes:
      a. The name and address of the school providing the training program;
      b. The name, title, telephone number, and e-mail address of the administrator or designee of the school;
      c. A list of each training program for which approval is being requested, including the number of hours of instruction provided for each;
   2. A copy of the curriculum that includes course titles and course descriptions; and
   3. A list of instructors providing the instruction and the credentials of each.
C. The Department shall:
   1. Review each application packet according to R9-16-621; and
   2. If approved, add the applicant’s school to the list of Department-approved educational programs in subsection (A).
D. If an applicant for certification or permit did not complete a Department-approved educational program, the applicant may submit to the Department a copy of the curriculum for the training program completed by the applicant with the applicant’s application packet in R9-16-606(B), R9-16-607(A), or R9-16-609(A).

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-603. Practical Technologist in Radiology - Eligibility and Scope of Practice
A. An individual is eligible for certification as a practical technologist in radiology if the individual:
   1. Is at least 18 years of age; and
   2. Either:
      a. Has completed a training program in radiologic technology through a Department-approved educational program;
      b. Meets the criteria in A.R.S. § 32-4302(A).
B. An individual certified as a practical technologist in radiology shall:
   2. Perform only:
      a. Chest radiography, and
      b. Radiography of the extremities; and
   3. Not use fluoroscopy or contrast media.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-604. Practical Technologist in Podiatry - Eligibility and Scope of Practice
A. An individual is eligible for certification as a practical technologist in podiatry if the individual:
   1. Is at least 18 years of age; and
   2. Either:
      a. Has:
         i. Completed a training program in podiatry radiology through a Department-approved educational program;
         ii. Received a signed and dated attestation from a podiatrist licensed according to A.R.S. Title 32, Chapter 7, verifying that the applicant:
            (1) Completed training under the direction of the licensed podiatrist, and
            (2) Is proficient in independently taking radiographs; and
         iii. Achieved a score of at least 70% on a Department-approved examination; or
      b. Meets the criteria in A.R.S. § 32-4302(A).
B. An individual certified as a practical technologist in podiatry shall:
   1. Follow the standards specified in the 2017 American Society of Radiologic Technologists Limited X-Ray Machine Operator Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_lxmo.pdf?sfvrsn=29e176d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
   2. Only perform radiographic examinations of the lower leg, ankle, and foot, without the use of fluoroscopy or contrast media.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-605. Practical Technologist in Bone Densitometry - Eligibility and Scope of Practice
A. An individual is eligible for certification as a practical technologist in bone densitometry if the individual:
   1. Is at least 18 years of age; and
   2. Either:
      a. Has:
         i. Completed a training program in bone densitometry through a Department-approved educational program and achieved a score of at least 70% on a Department-approved examination, or
         ii. Meets the criteria in A.R.S. § 32-4302(A).
B. An individual certified as a practical technologist in bone densitometry shall:
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A. Except as provided in subsection (B), an applicant for initial certification as a practical technologist in bone densitometry shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
2. Except as provided in R9-16-602(D), documentation of completion of a Department-approved educational program; and
3. For an applicant for examination as a practical technologist in podiatry, the attestation specified in R9-16-605(A).

B. An applicant for examination shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
   b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
   c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

C. The Department shall approve or deny an individual’s application for initial certification according to R9-16-621.

R9-16-607. Application for Initial Certification as a Practical Technologist in Radiology, Practical Technologist in Podiatry, or Practical Technologist in Bone Densitometry

A. Except as provided in subsection (B), an applicant for initial certification as a practical technologist in radiology, practical technologist in podiatry, or practical technologist in bone densitometry shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
2. Except as provided in R9-16-602(D), documentation of completion of a Department-approved educational program;
3. Documentation of achieving the applicable minimum score on a Department-approved examination;
4. For an application for a practical technologist in podiatry, the signed attestation in R9-16-604(A)(2)(a)(ii) containing:
   a. The name and date of birth of the applicant,
   b. The name and license number of the licensed podiatrist,
   c. A statement by the licensed podiatrist verifying completion of the applicant’s clinical training and approval of radiographic images taken by the applicant, and
   d. The licensed podiatrist’s signature and date; and
5. The applicable fee in R9-16-623.

B. If an applicant for initial certification as a practical technologist in radiology, practical technologist in podiatry, or practical technologist in bone densitometry may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:
1. The information and documentation required in R9-16-619;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
   b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
   c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

C. The Department shall approve or deny an individual’s application for initial certification according to R9-16-621.

R9-16-608. Radiologic Technologist, Nuclear Medicine Technologist, and Radiation Therapy Technologist - Eligibility and Scope of Practice

A. An individual is eligible to apply for initial certification as a radiologic technologist, nuclear medicine technologist, or radiation therapy technologist if the individual:
1. Is at least 18 years of age; and
2. Satisfies one of the following:
   a. Holds current applicable ARRT or NMTCB certification;
   b. Has completed a Department-approved educational program in radiation technology and has a passing score on a Department-approved examination, or
   c. Meets the criteria in A.R.S. § 32-4320(A).

B. An individual certified as a radiologic technologist shall follow the standards specified in the 2017 American Society of Radiologic Technologists Radiography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_rad.pdf?sfvrsn=13e176d0_18, incorporated by reference, on file with the Department, and including no future editions or amendments.

C. An individual certified as a nuclear medicine technologist shall:
C. The Department shall approve or deny an individual’s application for initial certification according to R9-16-621.

B. Except as provided in subsection (B), an applicant for initial certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist shall submit an application packet to the Department that includes:

1. The information and documents required in R9-16-619;
2. Either:
   a. A copy of the applicant’s current ARRT or NMTCB certification; or
   b. Documentation of:
      i. Completing a Department-approved educational program, except as provided in R9-16-602(D); and
      ii. Having a passing score on a Department-approved examination; and
3. The applicable fee in R9-16-623.

B. If an applicant for initial certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:

1. The information and documentation required in R9-16-619;
2. Documentation of the professional license or certification issued to the applicant by each state in which the applicant holds a professional license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified in another state for at least one year, with a scope of practice consistent with the scope of practice for which certification is being requested;
   b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
   c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

C. The Department shall approve or deny an individual’s application for initial certification according to R9-16-621.


Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-610. Mammographic Technologist - Eligibility and Scope of Practice

A. An individual is eligible to apply for initial certification as a mammographic technologist if the individual:
1. Is at least 18 years of age;
2. Possesses a current Department-issued certification in radiologic technology; and
3. Satisfies one of the following:
   a. Holds a current ARRT certification in mammography;
   b. Meets the initial training and education requirements in 21 CFR 900.12 and has a passing score on a Department-approved examination in mammography, or
   c. Meets the criteria in A.R.S. § 32-4302(A).

B. An individual certified as a mammographic technologist:
1. Shall follow the standards specified in the 2017 American Society of Radiologic Technologists Mammography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_mamm.pdf?sfvrsn=10e076d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
2. May perform diagnostic mammography or screening mammography, as defined in A.R.S. § 30-651.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-611. Student Mammography Permits

A. Before beginning the initial training in 21 CFR 900.12 under R9-16-610(A)(3)(b), an individual shall obtain a student mammography permit from the Department.

B. An applicant for a student mammography permit shall submit an application packet to the Department that includes:

1. The information and documents required under R9-16-619; and
2. A Department-provided agreement form that includes the following:
   a. The name and date of birth of the applicant;
   b. The name, license number, e-mail address, and telephone number of a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology;
   c. A statement that the licensed radiologist is accepting responsibility for the applicant’s supervision and training; and
   d. The licensed radiologist’s signature and date of signing.

C. The Department shall approve or deny an individual’s application for a student mammography permit according to R9-16-621.

D. A student mammography permit is valid for one year from the date issued and may not be renewed.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-612. Application for Initial Certification as a Mammographic Technologist

A. Before beginning the initial training in 21 CFR 900.12 under R9-16-610(A)(3)(b), an individual shall obtain a student mammography permit from the Department.

B. An applicant for a student mammography permit shall submit an application packet to the Department that includes:

1. The information and documents required under R9-16-619; and
2. A Department-provided agreement form that includes the following:
   a. The name and date of birth of the applicant;
   b. The name, license number, e-mail address, and telephone number of a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology;
   c. A statement that the licensed radiologist is accepting responsibility for the applicant’s supervision and training; and
   d. The licensed radiologist’s signature and date of signing.

C. The Department shall approve or deny an individual’s application for a student mammography permit according to R9-16-621.

D. A student mammography permit is valid for one year from the date issued and may not be renewed.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
A. Except as provided in subsection (B), an applicant for initial certification as a mammographic technologist shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
2. The applicant’s current radiology technologist certificate number;
3. The applicant’s current student mammography permit number, if applicable;
4. Either:
   a. A copy of current ARRT certification in mammography;
   b. Documentation of:
      i. Completing of initial education and training that meets the requirements specified in 21 CFR 900.12, and
      ii. Having a passing score on a Department-approved examination in mammography; and
5. The applicable fee in R9-16-623.

B. An individual certified as a computed tomography technologist:
1. Shall follow the standards specified in the 2017 American Society of Radiologic Technologists Computed Tomography Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_ct.pdf?sfvrsn=9e076d0_16, incorporated by reference, on file with the Department, and including no future editions or amendments; and
2. May apply ionizing radiation to a human using a computed tomography machine for diagnostic purposes.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-614. Application for Computed Tomography Technologist Preceptorship and Temporary Certification
A. Before beginning training under R9-16-613(A)(3)(b), an individual shall obtain a computed tomography preceptorship certificate from the Department.
B. An applicant for a computed tomography preceptorship certificate shall submit an application packet to the Department that includes:
1. The information and documents required under R9-16-619;
2. A Department-provided agreement form from a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology, that includes the following:
   a. The name and date of birth of the applicant;
   b. The name, license number, e-mail address, and telephone number of the licensed radiologist;
   c. A statement that the licensed radiologist is accepting responsibility for the applicant’s supervision and training; and
   d. The licensed radiologist’s signature and date of signing; and
3. The applicable fee in R9-16-623.
C. The Department shall approve or deny an individual’s application for a computed tomography preceptorship certificate according to R9-16-621.
D. A computed tomography preceptorship certificate is valid for one year from the date issued and may not be renewed.
E. At least 30 days before the expiration of an individual’s computed tomography preceptorship certificate, the individual may apply for a computed tomography temporary certificate by submitting an application packet to the Department that includes:
1. The information and documents required under R9-16-619;
2. A Department-provided agreement form from a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology, that includes the following:
   a. The name and date of birth of the applicant;
   b. The name, license number, e-mail address, and telephone number of the licensed radiologist;
   c. A statement that the licensed radiologist is accepting responsibility for the applicant’s supervision and training; and
   d. The licensed radiologist’s signature and date of signing; and
3. The applicable fee in R9-16-623.
F. The Department shall approve or deny an individual’s application for a computed tomography temporary certificate according to R9-16-621.
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G. A computed tomography temporary certificate is valid for one year and may not be renewed.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-615. Application for Initial Certification as a Computed Tomography Technologist

A. Except as provided in subsection (B), an applicant for initial certification as a computed tomography technologist shall submit an application packet to the Department that includes:
1. The information and documents required in R9-16-619;
2. The applicant’s current radiation technologist or nuclear medicine technologist certificate number;
3. The applicant’s computed tomography preceptorship number or temporary certificate number, if applicable;
4. Either:
   a. A copy of the applicant’s current ARRT or NMTCB certification in computed tomography; or
   b. Documentation of completion of:
      i. Two years of training in computed tomography, and
      ii. Twelve hours of computed tomography-specific education; and
5. The applicable fee in R9-16-623.

B. If an applicant for initial certification as a computed tomography technologist may be eligible for certification under A.R.S. § 32-4302(A), the applicant shall submit an application packet to the Department that includes:
1. The information and documentation required in R9-16-619;
2. Documentation of the license or certification as a computed tomography technologist issued to the applicant by each state in which the applicant holds the license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified as a computed tomography technologist in another state for at least one year;
   b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
   c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

C. The Department shall approve or deny an individual’s application for initial certification as a computed tomography technologist according to R9-16-621.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-616. Radiologist Assistant - Eligibility and Scope of Practice

A. An individual is eligible to apply for initial certification as a radiologist assistant if the individual:
1. Is at least 18 years of age; and
2. Satisfies one of the following:
   a. Holds a current ARRT or CBRPA certification as a radiologist assistant;
   b. Has:
      i. Completed a baccalaureate degree or post-baccalaureate certificate from an accredited educational institution that encompasses a radiologist assistant curriculum that includes a radiologist-directed clinical preceptorship, and
      ii. Achieved a passing score on an ARRT or a CBRPA examination for radiologist assistants; or
   c. Meets the criteria in A.R.S. § 32-4302(A).

B. An individual certified as a radiologist assistant:
1. Shall follow the standards specified the 2017 American Society of Radiologic Technologists Radiologist Assistant Practice Standards, available at https://www.asrt.org/docs/default-source/practice-standards-published/ps_raa.pdf?sfvrsn=1ae076d0_16, incorporated by reference on file with the Department, and including no future editions or amendments; and
2. May perform the following procedures under the direction of a radiologist, licensed under A.R.S. Title 32, Chapter 13 or 17 and certified in radiology by the American Board of Radiology:
   a. Fluoroscopy;
   b. Assessment and evaluation of the physiological and psychological responsiveness of individuals undergoing radiologic procedures;
   c. Evaluation of image quality, making initial image observations and communicating observations to the supervising radiologist; and
   d. Administration of contrast media or other medications prescribed by the supervising radiologist.

C. A radiologist assistant shall not interpret images, make diagnoses, or prescribe medications or therapies.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).
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2. Documentation of the license or certification as a radiologist assistant issued to the applicant by each state in which the applicant holds the license or certification;
3. A statement, signed and dated by the applicant, attesting that the applicant:
   a. Has been licensed or certified as a radiologist assistant in another state for at least one year;
   b. Has met minimum education requirements and, if applicable, work experience and clinical supervision requirements, according to A.R.S. § 32-4302(A)(3);
   c. Has not voluntarily surrendered a license or certification in any other state or country while under investigation for unprofessional conduct; and
   d. Does not have an complaint, allegation, or investigation pending before another regulatory entity in another state or country related to unprofessional conduct; and
4. The applicable fee in R9-16-623.

C. The Department shall approve or deny an individual’s application for initial certification as a radiologist assistant according to R9-16-621.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-618. Special Permits
A. An applicant for a special permit under A.R.S. § 32-2814(B) shall submit an application packet to the Department containing:
   1. The information and documents required in R9-16-619;
   2. An attestation, in a Department-provided format, from the health care institution in which the applicant proposes to practice:
      a. Stating that the requesting health care institution is located in an Arizona medically underserved area, as defined in A.A.C. R9-15-101(4), or a health professional shortage area, as defined in A.A.C. R9-15-101(25);
      b. Verifying that the health care institution developed and is implementing a program of continuing education for the applicant to protect the health and safety of individuals undergoing radiologic procedures; and
      c. Signed and dated by the health care institution’s administrator or designee; and
   3. A letter signed by the health care institution’s administrator or designee that provides justification for the issuance of a special permit.
B. The Department shall approve or deny an application for a special permit according to R9-16-621.
C. A special permit is valid for no more than one year, but may be renewed as provided in subsection (A) if the circumstances justifying the issuance of a special permit have not changed.

Historical Note
New Section made by final expedited rulemaking at 25 A.A.R. 2409, effective August 27, 2019 (Supp. 19-3).

R9-16-619. Application Information
An applicant for certification shall submit to the Department:
1. The following information in a Department-provided format:
   a. The applicant’s name;
   b. The applicant’s residential address and, if different, mailing address;
   c. The applicant’s telephone number;
   d. The applicant’s e-mail address;
   e. The applicant’s Social Security number, as required under A.R.S. §§ 25-320 and 25-502;
   f. The applicant’s date of birth;
   g. The applicant’s current employment in the radiation technology field, if applicable, including:
      i. The employer’s name,
      ii. The applicant’s position,
      iii. Dates of employment,
      iv. The address of the employer,
      v. The supervisor’s name,
      vi. The supervisor’s email address, and
      vii. The supervisor’s telephone number;
   h. The applicant’s educational history related to radiation technology, including:
      i. The name and address of each educational institution,
      ii. The degree or certification received, and
      iii. The applicant’s date of graduation;
   i. Whether the applicant has ever been convicted of a felony or a misdemeanor in this or another state;
   j. Whether the applicant holds other professional licenses or certifications and, if so:
      i. The professional license or certification, and
      ii. The state in which the professional license or certification was issued;
   k. Whether the applicant has a professional license or certificate suspended, revoked, or had disciplinary action taken against the professional license or certificate;
   l. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-621;
   m. Whether the applicant holds or is applying for another professional license, certification, or certificate;
   n. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-621;
   o. An attestation that the information submitted as part of an application packet is true and accurate; and
   p. The applicant’s signature and date of signing.
2. If the applicant has a professional license or certificate suspended, revoked, or had disciplinary action taken against the professional license or certificate within the previous five years, documentation that includes:
   a. The date of the disciplinary action, revocation, or suspension;
   b. The state or nationally accredited certifying body that issued the disciplinary action, revocation, or suspension; and
   c. An explanation of the disciplinary action, revocation, or suspension;
3. If the applicant is currently ineligible for licensing or certification in any state because of a license revocation or suspension, documentation that includes:
   a. The date of the ineligibility for licensing or certification,
   b. The state or jurisdiction of the ineligibility for licensing or certification, and
   c. An explanation of the ineligibility for licensing or certification; and
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R9-16-620. Renewal of Certification
A. Certifications issued under R9-16-607, R9-16-609, R9-16-612, R9-16-615, and R9-16-617 are valid for two years after issuance, unless revoked.
B. A certificate holder may apply to renew a certification:
1. Within 90 days before the expiration date of the certificate holder’s current certification;
2. Within the 30-day period after the expiration date of the certificate holder’s certification, if the certificate holder pays the late renewal penalty fee in R9-16-623; or
3. Within the extension time period granted under A.R.S. § 32-4301.
C. An applicant for renewal of a certification shall submit to the Department an application packet, including:
1. The following in a Department-provided format:
   a. The applicant’s name, address, telephone number, email address, date of birth, and Social Security number;
   b. The applicant’s current certification number and type;
   c. The applicant’s current employment in the radiation technology field, if applicable, including:
      i. The employer’s name,
      ii. The applicant’s position, iii. Dates of employment,
   d. Whether the applicant has, within the two years before the date of the application, had:
      i. A certificate issued under this Article suspended or revoked; or
      ii. A professional license or certificate revoked by another state, jurisdiction, or nationally recognized accreditation body;
   e. Whether the applicant agrees to allow the Department to submit supplemental requests for information under R9-16-621;
   f. Attestation that all the information submitted as part of the application packet is true and accurate; and
   g. The applicant’s signature and date of signature;
2. Either:
   a. An attestation that the applicant completed continuing education required under A.R.S. § 32-2815(D) and that documentation of completion is available upon request, signed and dated by the applicant; or
   b. A copy of the applicant’s current certification from a nationally recognized accreditation body; and
3. The applicable renewal fee and, if applicable, the late renewal penalty fee required in R9-16-623.
D. The Department shall approve or deny an application for recertification according to R9-16-621.

R9-16-621. Review Time-frames
A. For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the overall time-frame described in A.R.S. § 41-1072(2).

1. An applicant and the Department may agree in writing to extend the substantive review time-frame and the overall time-frame.
2. The extension of the substantive review time-frame and overall time-frame may not exceed 25% of the overall time-frame.
B. For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the administrative completeness review time-frame described in A.R.S. § 41-1072(1).
1. The administrative completeness review time-frame begins on the date the Department receives an application packet required in this Article.
2. Except as provided in subsection (B)(3), the Department shall provide written notice of administrative completeness or a notice of deficiencies to an applicant within the administrative completeness review time-frame.
   a. If an application packet is not complete, the notice of deficiencies shall list each deficiency and the information or documentation needed to complete the application packet.
   b. A notice of deficiencies suspends the administrative completeness review time-frame and the overall time-frame from the date of the notice until the date the Department receives the missing information or documentation.
   c. If the applicant does not submit to the Department all the information or documentation listed in the notice of deficiencies within 30 calendar days after the date of the notice of deficiencies, the Department shall consider the application packet withdrawn.
3. If the Department issues a certificate during the administrative completeness review time-frame, the Department shall not issue a separate written notice of administrative completeness.
C. For each type of certificate or permit issued by the Department under this Article, Table 6.1 specifies the substantive review time-frame described in A.R.S. § 41-1072(3), which begins on the date the Department sends a written notice of administrative completeness.
1. Within the substantive review time-frame, the Department shall provide written notice to the applicant that the Department approved or denied the application.
2. During the substantive review time-frame:
   a. The Department may make one comprehensive written request for additional information or documentation; and
   b. If the Department and the applicant agree in writing, the Department may make supplemental requests for additional information or documentation.
3. A comprehensive written request or a supplemental request for additional information or documentation suspends the substantive review time-frame and the overall time-frame from the date of the request until the date the Department receives all the information or documentation requested.
4. If the applicant does not submit to the Department all the information or documentation listed in a comprehensive written request or supplemental request for additional information or documentation within 30 calendar days after the date of the request, the Department shall deny the certificate or permit.
D. An applicant who is denied a certificate or permit may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.
A certificate holder may submit to the Department, either as a certificate holder may obtain a duplicate certificate by submitting the following nonrefundable fees:
1. A written request for a duplicate certificate, in a Department-provided format, that includes:
   a. The certificate holder’s name and address,
   b. The certificate holder’s certificate number and expiration date, and
   c. The certificate holder’s signature and date of signature; and
2. The duplicate certificate fee in R9-16-623.

C. A certificate holder may submit to the Department, either as a separate written document or as part of the renewal application, a signed and dated request to transfer to inactive status or retirement status under A.R.S. § 32-2816(F).

R9-16-623. Fees
A. Except as provided in subsection (C) or (D), an applicant shall submit to the Department the following nonrefundable fees for:
1. An initial application or renewal application for certification as a practical technician in radiology, practical technologist in podiatry, or practical technologist in bone densitometry, $100;
2. An initial application or renewal application for certification as a radiation technologist, nuclear medicine technologist, or radiation therapy technologist, $100;
3. An initial application or renewal application for certification as a mammographic technologist, $20;
4. A computed tomography preceptorship certificate or computed tomography temporary certificate, $10;
5. An initial application or renewal application for certification as a computed tomography technologist, $20;
6. An initial application or renewal application for certification as a radiologist assistant, $100; and
7. A late renewal penalty fee according to A.R.S. § 32-2816(C), $50.

B. The fee for a duplicate certificate is $10.

C. An applicant for initial certification is not required to submit the applicable fee in subsection (A) if the applicant, as part of the applicable application packet in R9-16-607, R9-16-609, R9-16-612, R9-16-615, or R9-16-617, submits an attestation that the applicant meets the criteria for waiver of licensing fees in A.R.S. § 41-1080.01.

D. As allowed under A.R.S. § 32-2816(F), a certificate holder is not required to submit a fee for renewal of certification if the certificate holder submits to the Department an affidavit stating that the certificate holder:
1. Is retired from the practice of radiologic technology, or
2. Requests to be placed on inactive status.

R9-16-624. Enforcement
A. The Department may, as applicable:
1. Deny, revoke, or suspend a certificate or permit under A.R.S. § 36-2821;
2. Request an injunction under A.R.S. § 36-2825; or
3. Assess a civil money penalty under A.R.S. § 36-2821.

B. In determining which disciplinary action specified in subsection (A) is appropriate, the Department shall consider:
1. The type of violation,
2. The severity of the violation,
3. The danger to public health and safety,
4. The number of violations,
5. The number of individuals affected by the violations,
6. The degree of harm to an individual,
7. A pattern of noncompliance, and
8. Any mitigating or aggravating circumstances.

C. A certificate holder or permittee may appeal a disciplinary action taken by the Department according to A.R.S. Title 41, Chapter 6, Article 10.
36-104. Powers and duties

This section is not to be construed as a statement of the department's organization. This section is intended to be a statement of powers and duties in addition to the powers and duties granted by section 36-103. The director shall:

1. Administer the following services:
   (a) Administrative services, which shall include at a minimum the functions of accounting, personnel, standards certification, electronic data processing, vital statistics and the development, operation and maintenance of buildings and grounds used by the department.
   (b) Public health support services, which shall include at a minimum:
      (i) Consumer health protection programs, consistent with paragraph 25 of this section, that include at least the functions of community water supplies, general sanitation, vector control and food and drugs.
      (ii) Epidemiology and disease control programs that include at least the functions of chronic disease, accident and injury control, communicable diseases, tuberculosis, venereal disease and others.
      (iii) Laboratory services programs.
   (iv) Health education and training programs.
   (v) Disposition of human bodies programs.
   (c) Community health services, which shall include at a minimum:
      (i) Medical services programs that include at least the functions of maternal and child health, preschool health screening, family planning, public health nursing, premature and newborn program, immunizations, nutrition, dental care prevention and migrant health.
      (ii) Dependency health care services programs that include at least the functions of need determination, availability of health resources to medically dependent individuals, quality control, utilization control and industry monitoring.
      (iii) Children with physical disabilities services programs.
   (iv) Programs for the prevention and early detection of an intellectual disability.
   (d) Program planning, which shall include at least the following:
      (i) An organizational unit for comprehensive health planning programs.
      (ii) Program coordination, evaluation and development.
      (iii) Need determination programs.
      (iv) Health information programs.
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2. Include and administer, within the office of the director, staff services, which shall include at a minimum budget preparation, public information, appeals, hearings, legislative and federal government liaison, grant development and management and departmental and interagency coordination.

3. **Make rules for the organization and proper and efficient operation of the department.**

36-136. **Powers and duties of director; compensation of personnel; rules; definitions**

A. The director shall:

1. Be the executive officer of the department of health services and the state registrar of vital statistics but shall not receive compensation for services as registrar.

2. Perform all duties necessary to carry out the functions and responsibilities of the department.

3. Prescribe the organization of the department. The director shall appoint or remove personnel as necessary for the efficient work of the department and shall prescribe the duties of all personnel. The director may abolish any office or position in the department that the director believes is unnecessary.

4. Administer and enforce the laws relating to health and sanitation and the rules of the department.

5. Provide for the examination of any premises if the director has reasonable cause to believe that on the premises there exists a violation of any health law or rule of this state.

6. Exercise general supervision over all matters relating to sanitation and health throughout this state. When in the opinion of the director it is necessary or advisable, a sanitary survey of the whole or of any part of this state shall be made. The director may enter, examine and survey any source and means of water supply, sewage disposal plant, sewerage system, prison, public or private place of detention, asylum, hospital, school, public building, private institution, factory, workshop, tenement, public washroom, public restroom, public toilet and toilet facility, public eating room and restaurant, dairy, milk plant or food manufacturing or processing plant, and any premises in which the director has reason to believe there exists a violation of any health law or rule of this state that the director has the duty to administer.

7. Prepare sanitary and public health rules.

8. Perform other duties prescribed by law.

B. If the director has reasonable cause to believe that there exists a violation of any health law or rule of this state, the director may inspect any person or property in transportation through this state, and any car, boat, train, trailer, airplane or other vehicle in which that person or property is transported, and may enforce detention or disinfection as reasonably necessary for the public health if there exists a violation of any health law or rule.
C. The director, after consultation with the department of administration, may take all necessary steps to enhance the highest and best use of the state hospital property, including contracting with third parties to provide services, entering into short-term lease agreements with third parties to occupy or renovate existing buildings and entering into long-term lease agreements to develop the land and buildings. The director shall deposit any monies collected from contracts and lease agreements entered into pursuant to this subsection in the Arizona state hospital charitable trust fund established by section 36-218. At least thirty days before issuing a request for proposals pursuant to this subsection, the department of health services shall hold a public hearing to receive community and provider input regarding the highest and best use of the state hospital property related to the request for proposals. The department shall report to the joint committee on capital review on the terms, conditions and purpose of any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, and the fiscal impact on the department and any revenues generated by the agreement. Any lease or sublease agreement entered into pursuant to this subsection relating to state hospital lands or buildings or the disposition of real property pursuant to this subsection, including state hospital lands or buildings, must be reviewed by the joint committee on capital review.

D. The director may deputize, in writing, any qualified officer or employee in the department to do or perform on the director’s behalf any act the director is by law empowered to do or charged with the responsibility of doing.

E. The director may delegate to a local health department, county environmental department or public health services district any functions, powers or duties that the director believes can be competently, efficiently and properly performed by the local health department, county environmental department or public health services district if:

1. The director or superintendent of the local health agency, environmental agency or public health services district is willing to accept the delegation and agrees to perform or exercise the functions, powers and duties conferred in accordance with the standards of performance established by the director of the department of health services.

2. Monies appropriated or otherwise made available to the department for distribution to or division among counties or public health services districts for local health work may be allocated or reallocated in a manner designed to ensure the accomplishment of recognized local public health activities and delegated functions, powers and duties in accordance with applicable standards of performance. If in the director’s opinion there is cause, the director may terminate all or a part of any delegation and may reallocate all or a part of any funds that may have been conditioned on the further performance of the functions, powers or duties conferred.
F. The compensation of all personnel shall be as determined pursuant to section 38-611.

G. The director may make and amend rules necessary for the proper administration and enforcement of the laws relating to the public health.

36-765. Definitions

In this article, unless the context otherwise requires:

1. "Certified community health worker" means a community health worker to whom the department has issued a certificate to practice as a certified community health worker in this state.

2. "Community health worker" means a nonmedical health worker who serves as a liaison for health and community service providers and enrollees to facilitate access to services and improve the quality of service delivery, including the coordination of services to improve medical and behavioral health outcomes.

3. "Department" means the department of health services.

4. "Director" means the director of the department.

5. "Practice as a certified community health worker" means a community health worker's application of the education, training and experience in the core competencies to effectively provide services to the communities and populations that the community health worker serves through one or more of the community health worker's roles.

36-765.01. Application for certificate; certification; renewal

A. A person may apply to the director for a certificate to practice as a certified community health worker on a form prescribed by the director and shall furnish information required by the director.

B. The director shall grant a community health worker certificate to a person who meets the qualifications prescribed by this article and rules adopted pursuant to this article and who pays the applicable fees.

C. A certificate is valid for two years and may be renewed once every two years by applying to the director and paying the applicable fees.

D. A person shall file an application for renewal at least thirty days and not more than sixty days before the expiration date of the current certificate.

36-765.02. Powers and duties of director; rules

A. The director, by rule, shall:

1. Prescribe the scope of practice and the core competencies of certified community health workers, including skills and areas of knowledge that are essential to bring about expanded health and wellness in diverse communities and to reduce health disparities.

2. Describe and define reasonable and necessary minimum qualifications, including education and training requirements, for certified community health workers.
3. Establish standards and requirements for the establishment of certified community health worker education and training programs in this state.

4. Adopt standards and requirements for the approval or acceptance of continuing education courses and programs for the renewal of a certificate.

5. Establish minimum education, training, experience and other qualifications that a certified community health worker must possess to qualify as a trainer in any education, training or continuing education program for certified community health workers.

6. Establish the criteria for granting, denying, suspending and revoking a certificate in order to protect the health and safety of the public.

B. The director may adopt rules:
   1. That are necessary for the proper administration and enforcement of this article.
   2. That allow for reciprocity agreements, including with the Indian health service.

C. The director shall waive the minimum training and education requirements for certification for applicants who provide documentation of at least nine hundred sixty hours of paid or volunteer experience providing community health worker services in the core competencies during the previous three years in a licensed health care facility or in the service of a licensed health care provider or a contractor under chapter 29, article 1 of this title.

36-765.03. Denial, suspension or revocation of certificate; disciplinary action; appeal

A. The director may deny, suspend or revoke the certificate of any community health worker who:
   1. Violates any provision of this article or rule adopted pursuant to this article.
   2. Has been convicted of a felony or a misdemeanor involving moral turpitude.
   3. Indulges in conduct or a practice detrimental to the health or safety of the public.

B. The department may deny, suspend or revoke a certificate without holding a hearing. After receiving notification of the denial, suspension or revocation, the applicant may request a hearing to review the denial, suspension or revocation. If requested, the department shall conduct a hearing to deny, suspend or revoke a certificate pursuant to title 41, chapter 6, article 10.

C. If the director determines pursuant to a hearing that grounds exist to deny, suspend or revoke a certificate, the director may do so permanently or for a fixed period of time and may impose conditions as prescribed by rule.

D. A certified community health worker employed by a tribe who violates this section shall be under tribal government jurisdiction. If the worker is determined to have violated this section, the information provided to the director may result in the denial, suspension or revocation of the worker’s certification. Internal
hearings, appeals or penalties resulting from disciplinary actions by a tribal government are deemed as the final decision in accordance with this section.

36-765.04. Investigations; evidence
The director may investigate information that indicates a person may be violating this article. In connection with an investigation, the director may examine and copy documents and other physical evidence wherever located that relate to the conduct or competency of a community health worker pursuant to the requirements of this article.

36-765.05. Fees; use
The director, by rule, shall establish and collect nonrefundable fees for certification that are consistent with fees that are prescribed pursuant to section 36-1908. The department shall deposit the fees in a segregated account in the health services licensing fund established by section 36-414.
CHAPTER 300

HOUSE BILL 2324

AN ACT

AMENDING TITLE 36, CHAPTER 6, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 7.1; RELATING TO PUBLIC HEALTH.

(TEXT OF BILL BEGINS ON NEXT PAGE)
Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 6, Arizona Revised Statutes, is amended by adding article 7.1, to read:

ARTICLE 7.1. COMMUNITY HEALTH WORKERS

36-765. Definitions
IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:
1. "CERTIFIED COMMUNITY HEALTH WORKER" MEANS A COMMUNITY HEALTH WORKER TO WHOM THE DEPARTMENT HAS ISSUED A CERTIFICATE TO PRACTICE AS A CERTIFIED COMMUNITY HEALTH WORKER IN THIS STATE.
2. "COMMUNITY HEALTH WORKER" MEANS A NONMEDICAL HEALTH WORKER WHO SERVES AS A LIAISON FOR HEALTH AND COMMUNITY SERVICE PROVIDERS AND ENROLLEES TO FACILITATE ACCESS TO SERVICES AND IMPROVE THE QUALITY OF SERVICE DELIVERY, INCLUDING THE COORDINATION OF SERVICES TO IMPROVE MEDICAL AND BEHAVIORAL HEALTH OUTCOMES.
3. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES.
4. "DIRECTOR" MEANS THE DIRECTOR OF THE DEPARTMENT.
5. "PRACTICE AS A CERTIFIED COMMUNITY HEALTH WORKER" MEANS A COMMUNITY HEALTH WORKER'S APPLICATION OF THE EDUCATION, TRAINING AND EXPERIENCE IN THE CORE COMPETENCIES TO EFFECTIVELY PROVIDE SERVICES TO THE COMMUNITIES AND POPULATIONS THAT THE COMMUNITY HEALTH WORKER SERVES THROUGH ONE OR MORE OF THE COMMUNITY HEALTH WORKER'S ROLES.

36-765.01. Application for certificate; certification; renewal
A. A person may apply to the director for a certificate to practice as a certified community health worker on a form prescribed by the director and shall furnish information required by the director.
B. The director shall grant a community health worker certificate to a person who meets the qualifications prescribed by this article and rules adopted pursuant to this article and who pays the applicable fees.
C. A certificate is valid for two years and may be renewed once every two years by applying to the director and paying the applicable fees.
D. A person shall file an application for renewal at least thirty days and not more than sixty days before the expiration date of the current certificate.

36-765.02. Powers and duties of director; rules
A. The director, by rule, shall:
1. Prescribe the scope of practice and the core competencies of certified community health workers, including skills and areas of knowledge that are essential to bring about expanded health and wellness in diverse communities and to reduce health disparities.
2. Describe and define reasonable and necessary minimum qualifications, including education and training requirements, for certified community health workers.
3. ESTABLISH STANDARDS AND REQUIREMENTS FOR THE ESTABLISHMENT OF
CERTIFIED COMMUNITY HEALTH WORKER EDUCATION AND TRAINING PROGRAMS IN THIS
STATE.

4. ADOPT STANDARDS AND REQUIREMENTS FOR THE APPROVAL OR ACCEPTANCE
OF CONTINUING EDUCATION COURSES AND PROGRAMS FOR THE RENEWAL OF A
CERTIFICATE.

5. ESTABLISH MINIMUM EDUCATION, TRAINING, EXPERIENCE AND OTHER
QUALIFICATIONS THAT A CERTIFIED COMMUNITY HEALTH WORKER MUST POSSESS TO
QUALIFY AS A TRAINER IN ANY EDUCATION, TRAINING OR CONTINUING EDUCATION
PROGRAM FOR CERTIFIED COMMUNITY HEALTH WORKERS.

6. ESTABLISH THE CRITERIA FOR GRANTING, DENYING, SUSPENDING AND
REVOKING A CERTIFICATE IN ORDER TO PROTECT THE HEALTH AND SAFETY OF THE
PUBLIC.

B. THE DIRECTOR MAY ADOPT RULES:
1. THAT ARE NECESSARY FOR THE PROPER ADMINISTRATION AND ENFORCEMENT
OF THIS ARTICLE.
2. THAT ALLOW FOR RECIPROCITY AGREEMENTS, INCLUDING WITH THE INDIAN
HEALTH SERVICE.

C. THE DIRECTOR SHALL WAIVE THE MINIMUM TRAINING AND EDUCATION
REQUIREMENTS FOR CERTIFICATION FOR APPLICANTS WHO PROVIDE DOCUMENTATION OF
AT LEAST NINE HUNDRED SIXTY HOURS OF PAID OR VOLUNTEER EXPERIENCE
PROVIDING COMMUNITY HEALTH WORKER SERVICES IN THE CORE COMPETENCIES DURING
THE PREVIOUS THREE YEARS IN A LICENSED HEALTH CARE FACILITY OR IN THE
SERVICE OF A LICENSED HEALTH CARE PROVIDER OR A CONTRACTOR UNDER CHAPTER
29, ARTICLE 1 OF THIS TITLE.

36-765.03. Denial, suspension or revocation of certificate;
disciplinary action; appeal

A. THE DIRECTOR MAY DENY, SUSPEND OR REVOKE THE CERTIFICATE OF ANY
COMMUNITY HEALTH WORKER WHO:
1. VIOLATES ANY PROVISION OF THIS ARTICLE OR RULE ADOPTED PURSUANT
TO THIS ARTICLE.
2. HAS BEEN CONVICTED OF A FELONY OR A MISDEMEANOR INVOLVING MORAL
TURPITUDE.
3. INDULGES IN CONDUCT OR A PRACTICE DETRIMENTAL TO THE HEALTH OR
SAFETY OF THE PUBLIC.

B. THE DEPARTMENT MAY DENY, SUSPEND OR REVOKE A CERTIFICATE WITHOUT
HOLDING A HEARING. AFTER RECEIVING NOTIFICATION OF THE DENIAL, SUSPENSION
OR REVOCATION, THE APPLICANT MAY REQUEST A HEARING TO REVIEW THE DENIAL,
SUSPENSION OR REVOCATION. IF REQUESTED, THE DEPARTMENT SHALL CONDUCT A
HEARING TO DENY, SUSPEND OR REVOKE A CERTIFICATE PURSUANT TO TITLE 41,
CHAPTER 6, ARTICLE 10.

C. IF THE DIRECTOR DETERMINES PURSUANT TO A HEARING THAT GROUNDS
EXIST TO DENY, SUSPEND OR REVOKE A CERTIFICATE, THE DIRECTOR MAY DO SO
PERMANENTLY OR FOR A FIXED PERIOD OF TIME AND MAY IMPOSE CONDITIONS AS
PRESCRIBED BY RULE.
D. A CERTIFIED COMMUNITY HEALTH WORKER EMPLOYED BY A TRIBE WHO VIOLATES THIS SECTION SHALL BE UNDER TRIBAL GOVERNMENT JURISDICTION. IF THE WORKER IS DETERMINED TO HAVE VIOLATED THIS SECTION, THE INFORMATION PROVIDED TO THE DIRECTOR MAY RESULT IN THE DENIAL, SUSPENSION OR REVOCATION OF THE WORKER’S CERTIFICATION. INTERNAL HEARINGS, APPEALS OR PENALTIES RESULTING FROM DISCIPLINARY ACTIONS BY A TRIBAL GOVERNMENT ARE DEEMED AS THE FINAL DECISION IN ACCORDANCE WITH THIS SECTION.

36-765.04. Investigations; evidence
THE DIRECTOR MAY INVESTIGATE INFORMATION THAT INDICATES A PERSON MAY BE VIOLATING THIS ARTICLE. IN CONNECTION WITH AN INVESTIGATION, THE DIRECTOR MAY EXAMINE AND COPY DOCUMENTS AND OTHER PHYSICAL EVIDENCE WHEREVER LOCATED THAT RELATE TO THE CONDUCT OR COMPETENCY OF A COMMUNITY HEALTH WORKER PURSUANT TO THE REQUIREMENTS OF THIS ARTICLE.

36-765.05. Fees; use
THE DIRECTOR, BY RULE, SHALL ESTABLISH AND COLLECT NONREFUNDABLE FEES FOR CERTIFICATION THAT ARE CONSISTENT WITH FEES THAT ARE PRESCRIBED PURSUANT TO SECTION 36-1908. THE DEPARTMENT SHALL DEPOSIT THE FEES IN A SEGREGATED ACCOUNT IN THE HEALTH SERVICES LICENSING FUND ESTABLISHED BY SECTION 36-414.

36-765.06. Certification not required
THIS ARTICLE DOES NOT REQUIRE COMMUNITY HEALTH WORKERS TO BE CERTIFIED BY THE DEPARTMENT IN ORDER TO PRACTICE AS A COMMUNITY HEALTH WORKER.

36-765.07. Public contracts; no preference
THIS STATE AND POLITICAL SUBDIVISIONS OF THIS STATE MAY NOT PROVIDE A PREFERENCE IN AWARDING A PUBLIC CONTRACT FOR SERVICES PROVIDED BY A CERTIFIED COMMUNITY HEALTH WORKER OR AN ENTITY THAT EMPLOYS CERTIFIED COMMUNITY HEALTH WORKERS.

Sec. 2. Community health workers advisory council; delayed repeal
A. The community health workers advisory council is established consisting of nine members, the majority of whom are community health workers, who are residents of this state, who represent the geographic region of this state where they reside and who are appointed by the director of the department of health services. The council shall make recommendations to the department regarding:
1. Core competencies for the certification of community health workers.
3. Standards and requirements for community health worker education and training programs.
4. Standards and requirements for continuing education courses and programs.
5. Minimum education and training standards for educators.
6. The type of certification examination or other means to assess community health worker competency for certification.
7. Standards for unprofessional conduct.
8. Any other matter as requested by the director.
8. This section is repealed from and after December 31, 2022.

APPROVED BY THE GOVERNOR MAY 16, 2018.

DEPARTMENT OF CHILD SAFETY (Expedited Rulemaking)
Title 21, Chapter 5

Amend:      R21-5-421
MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 10, 2022

SUBJECT: Department of Child Safety
Title 21, Chapter 5

Amend: R21-5-421

Summary:

This expedited rulemaking from the Department of Child Safety relates to rules in Title 21, Chapter 5 regarding Permanency and Support Services. The Department seeks to amend one rule in response to the 5YRR proposed course of action for these rules, which was approved by the Council on June 2, 2020. A.R.S. 8-112 states a social study report shall be submitted 10 days before the hearing on the petition to adopt, while the rule, R21-5-421, states the report shall be submitted at least 14 days before the hearing. The Department seeks to amend R21-5-421 to align the timeframes in the rule with the timeframes in statute, reducing any potential confusion.

The Department received approval from the rulemaking moratorium to initiate this rulemaking on February 16, 2022 and final approval to submit to the Council on June 28, 2022.

1. **Do the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)?**

Yes. The Department states that the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A) under (7) (“Implements, without material change, a
course of action that is proposed in a five-year review report approved by the council pursuant to section 41-1056 within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the secretary of state.”

2. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   Yes, the Department cites to both general and specific statutory authority.

3. **Do the rules establish a new fee or contain a fee increase?**

   No, the rules do not establish a new fee or contain a fee increase.

4. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

   The Department indicates they did not receive any comments.

5. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

   No, the Department did not make any changes between the proposed expedited rulemaking and the final expedited rulemaking.

6. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

   No, the rules are not more stringent than the corresponding federal laws; Families Act (ASFA) (P.L. 105-89), Adam Walsh Child Protection and Safety (P.L. 109-248), Adoption Promotion Act 2003 (P.L. 108-145), and Keeping Children and Families Safe Act 2003 (P.L. 108-36).

7. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

   Not applicable. The rules do not require the issuance of a general permit or license.

8. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   The Department did not review or rely on any study for this expedited rulemaking.
9. **Conclusion**

In this expedited rulemaking the Department seeks to amend the rules in response to their 5YRR proposed course of action. If approved, this rulemaking would be effective immediately upon the Department filing the Notice of Final Expedited Rulemaking and Certificate of Approval with the Secretary of State. The Department meets the criteria for Expedited Rulemaking pursuant to A.R.S. § 41-1027(A)(7).

Council staff recommends approval of this expedited rulemaking.
July 6, 2022

VIA EMAIL:  grrc@azdoa.gov
Ms. Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Title 21, Chapter 5 Article 4 Notice of Final Expedited Rulemaking

Dear Ms. Sornsin:

The attached final rulemaking package is respectfully submitted for review and approval by the Council. The following information is provided for your use in reviewing the rulemaking package:

A.  Close of Record Date:
The rulemaking record closed on May 13, 2022. This rulemaking package is being submitted within the 120 days allowed for Final Rulemaking. An oral proceeding was not held; however, information to provide comments or request an oral proceeding was posted on the DCS webpage and in the Notice of Proposed Expedited Rulemaking. No verbal or written comments were received during the comment period.

B.  An explanation of how the expedited rule meets the criteria in A.R.S. 41-1027(A):
The amendments are justified under A.R.S. 41-1027(A) because they will not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated and they implement, without material change, courses of action proposed in the Department's Five-Year Review Report approved by Governor's Regulatory Review Council on June 2, 2020.

C.  Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:
This rulemaking relates to a five-year-review report. GRRC approved the five-year-review report on June 2, 2020.
F. A certification that the preamble discloses a reference to any study relevant to the rule that the agency reviewed and either did or did not rely on in the agency’s evaluation or justification for the rule:
The Department certifies that the preamble accurately discloses that a study was not conducted or relied on in the agency’s evaluation or justification of the rule.

H. A list of all documents enclosed:
1. Notice of Final Expedited Rulemaking including preamble, table of contents for the rulemaking, and rule text
2. Copy of the authorizing and implementing statutes
3. Copy of current rules
4. Governor’s Office Approval via email from the Policy Advisor. (Approval of the request of an exemption to the rulemaking moratorium and approval of the Notice of Final Expedited Rulemaking)

If you have any questions, please contact Angie Trevino, Rules Development and Policy Specialist at (602) 619-3163 or by email at angelica.trevino@azdcs.gov.

Sincerely,

[Signature]

Mike Faust
Director

Enclosure
NOTICE OF FINAL EXPEDITED RULEMAKING

TITLE 21. CHILD SAFETY

CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

PREAMBLE

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

   R21-5-421   Amend

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

   Authorizing statute: A.R.S. § 8-453(A)(5)

   Implementing statute: A.R.S. §§ 8-105, 8-106, 8-112, 8-120, 8-121, 8-129, 8-130, 8-171, 8-172, 8-173

3. The effective date of the rule:

   Effective upon filing with the Office of Secretary of State.

4. Citations to all related notices published in the Register as prescribed in R1-1-409(A) that pertain to the record of the final rulemaking package:

   Notice of Rulemaking Docket Opening: 28 A.A.R. 819, April 22, 2022

   Notice of Proposed Expedited Rulemaking: 28 A.A.R. 816, April 22, 2022

5. The agency’s contact person who can answer questions about the rulemaking:

   Name: Angie Trevino, Rule Development Specialist

   Address: Department of Child Safety
6. **An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, under A.R.S. 41-1027, to include an explanation about the rulemaking:**

The proposed amendments are justified under A.R.S. § 41-1027 because they will not increase the cost of regulatory compliance, increase a fee, or reduce procedural rights of persons regulated. The proposed amendments will implement, without material change, courses of action proposed in the Department's Five-Year-Review Report approved by the Governor's Regulatory Review Council on June 2, 2020.

The rules in A.A.C. R21-5-421(1) states that a final written report shall be filed with the court at least 14 calendar days before the final adoption hearing, while A.R.S. § 8-112 states that a social study (report) shall be submitted ten days before the hearing on the petition to adopt. As written, the discrepancy between A.A.C. and A.R.S. manifests when there is a state holiday. The proposed amendment will align the timeframes in rule with the timeframes in statute in an effort to reduce potential confusion.

7. **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 Department of Child Safety (DCS) did not review or rely on any study for this rulemaking.

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

Not applicable

9. A summary of the economic, small business, and consumer impact:

Under A.R.S. § 41-1055(D)(2), the Department is not required to provide an economic, small business, and consumer impact statement.

10. A description of any changes between the proposed expedited rulemaking, to include supplemental notices, and the final expedited rulemaking:

The Department of Child Safety made no changes between the proposed expedited rulemaking and this final expedited rulemaking.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department of Child Safety did not receive public or stakeholder comments about the expedited rulemaking.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additional matters shall include but are not limited to:

a. Whether the rule requires a permit, whether a permit, license, or agency authorization under A.R.S. 41-1037(A), and whether a general permit is used and if not, the reasons why a general permit is not used:

The rules in this Article do not require the issuance of a regulatory permit. A general permit is not applicable.
b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Federal laws that apply to the rules of this Article includes the following: Adoption and Safe Families Act (ASFA) (P.L. 105-89); Adam Walsh Child Protection and Safety (P.L. 109-248); Adoption Promotion Act 2003 (P.L. 108-145); and Keeping Children and Families Safe Act 2003 (P.L. 108-36). The rules in this Article are not more stringent than federal law.

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 such analysis was submitted.

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

None

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable

15. The full text of the rules follows:
ARTICLE 4. ADOPTION ENTITY SERVICES

Section

R21-5-421. Finalizing the Placement
ARTICLE 4. ADOPTION ENTITY SERVICES

R21-5-421. Finalizing the Placement

An adoption entity shall cooperate with the adoptive parent and the attorney, if any, retained by the adoptive parent, to finalize the adoption.

1. The entity shall provide all information and documents needed to finalize the adoption and shall file a final written report to the court at least 10 days before the final adoption hearing, or at such other time as the Court may require. The report shall include the information listed in this subsection, unless the entity has already provided this information in an earlier report, and the information has not changed since the earlier report.

   a. The name and age of each adoptive parent and the relationship, if any, of each adoptive parent to the child to be adopted;

   b. The name, age, and birthplace of the child to be adopted, and whether any or all of this information is unknown to the adoptive parent;

   c. The entity or other source from which the adoptive parent received the child to be adopted;

   d. The circumstances surrounding the surrender of the child to the entity;

   e. The results of the entity’s evaluation of the child and of the adoptive parent, including:

      i. A description of the care the child is receiving;

      ii. The adjustment of the child and parent; and

      iii. A summary statement of the entity’s recommendation to the court regarding finalization;

   f. A full description of any property belonging to the child to be adopted;

2. No Change
3. No Change
CHAPTER 5. DEPARTMENT OF CHILD SAFETY - PERMANENCY AND SUPPORT SERVICES

k. Assisting an attorney by providing legal documents to enable an adoptive parent to complete the adoption process.

B. When performing adoption services, the Department shall adhere to the standards established for an adoption agency in 21 A.A.C. 9.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-304. Department Procedures for Processing Certification Applications

A. Upon review of a certification application, the Department shall notify the applicant in writing that the application is either complete or incomplete. An application is complete when it contains the information and supporting documentation described in R21-5-404. If the application is incomplete, the notice shall specify what information is missing.

B. An applicant with an incomplete application has 30 days from the date of the notice to provide the missing information. If the applicant fails to do so, the Department may close the file. An applicant whose file has been closed and who later wishes to apply for certification may reapply.

C. Upon review of a complete application, the Department shall decide whether to accept the application, according to the priority schedule listed in R21-5-305, and the availability of the Department’s resources. If the Department cannot accept the application, the Department shall return the original application and all supporting documentation to the applicant. The applicant may reapply.

D. After the Department accepts the completed application, the Department shall provide the applicant written notice of the acceptance. The Department shall complete the certification investigation as specified in R21-5-405 within 90 days of the date of the notice. The Department shall prepare a certification report under R21-5-406.

E. The Department shall process a renewal application under this Section and R21-5-407.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-305. Department Priorities for Receipt of Services

The Department shall accept and process certification applications and render adoption services according to the following priority schedule:

1. An applicant for whom the court has ordered the Department to do a certification investigation and report;
2. An applicant seeking to adopt a particular adoptable child with special needs;
3. An applicant wishing to adopt a child with special needs;
4. An applicant considering adopting a child with special needs; and
5. All other applicants.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-306. Department Recruitment Efforts

The Department shall actively recruit persons to adopt children with special needs by:

1. Publicizing the need for such adoptive parents;
2. Registering adoptable children, as appropriate, with the Adoption Registry or other local, state, regional and national adoption resources;
3. Advising prospective adoptive parents of:
   a. The availability of children with special needs,
   b. The procedures involved in adopting such children, and
   c. The support services and subsidies that may be available to persons adopting such children; and
4. Other measures similar to those described in this Section.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-307. Expired

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).
Section expired under A.R.S. § 41-1056(J) at 26 A.A.R. 1322, effective June 3, 2020 (Supp. 20-2).

R21-5-308. Termination of Adoption Services

A. The Department may terminate services to an applicant or adoptive parent when:
   1. The adoption is finalized;
   2. The applicant or adoptive parent requests closure before receiving a child for placement;
   3. The applicant or adoptive parent ceases to be a resident of Arizona before receiving a child for placement;
   4. The court declines to certify the applicant or adoptive parent;
   5. The applicant or adoptive parent refuses to comply with the requirements in A.R.S. Title 8, Chapter 1, Article 1, or this Chapter, Articles 3 and 4;
   6. The applicant fails to submit a completed certification application within 90 days of the date on which the Department sent the person an application form;
   7. The adoptive parent is no longer willing to be an adoptive parent; or
   8. The adoptive parent is no longer certified to adopt.

B. The Department may terminate adoption services to an adoptive child when:
   1. The court issues a final adoption order; or
   2. The court determines that adoption is no longer the most appropriate case plan for the child, and the Department provides alternate services consistent with the child’s new case plan.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

ARTICLE 4. ADOPTION ENTITY SERVICES

R21-5-401. Definitions

The definitions in R21-5-301 apply in this Article.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-402. Recruitment

A. When recruiting applicants, an adoption entity shall comply with the requirements of this Section.

B. The adoption entity shall conduct recruitment efforts pursuant to a written plan, which shall describe:
   1. Specific recruitment goals, including:
      a. The number and composition of adoptive parents the entity will serve; and
      b. The children the entity will accept for placement and any limitations such as:
         i. Age;
         ii. Medical special needs;
iii. Developmental special needs;
iv. Mental health; or behavioral health special needs.

2. Methods of recruitment;
3. The number and professional qualifications of staff designated to handle recruitment; and
4. The means by which the adoption entity shall fund the agency’s recruitment efforts.

C. The adoption entity’s recruitment efforts shall be consistent with the personal characteristics of the children the entity has available for adoption and reasonably expects will become available for adoption through the entity.

D. An adoption entity shall not:
1. Promise to place more children than the adoption entity’s prior history shows it can reasonably expect to place;
2. Promise to place a child in less time than the average waiting period demonstrated by the adoption entity’s past practice;
3. Promise adoption subsidy prior to the formal approval and receipt of an adoption assistance agreement that meets the requirements of A.R.S. Title 8 Chapter 1 Article 2; or
4. Make any other statements or promises the entity knows or reasonably should know are false, misleading, or inaccurate.

E. The Department may take an adverse licensing action against an adoption agency that does not comply with this Section.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-403. Orientation: Persons Interested in Adoption

A. Prior to accepting a certification application from a person considering the adoption of a child, or an application for placement from a person who intends to seek a placement through the adoption entity, an adoption entity shall provide the person with an adoption orientation, which shall explain the following:

1. The adoption process, including all legally mandated procedures, and estimated time-frames for completion of such procedures;
2. The adoption entity’s policies and procedures that directly affect services to adoptive parents;
3. The adoption entity’s fee structure and written fee agreement;
4. The types and number of children the agency typically has had and reasonably expects to have available for adoption placement and the average length of time between certification and placement;
5. The Department’s responsibility for licensing and monitoring agencies, and the public’s right to register a complaint about an agency as prescribed in 21 A.A.C. 9, Article 2;
6. The function of the Adoption Registry and the adoptive parent’s right to decide whether to be included in the Adoption Registry; and
7. Confidentiality requirements, open adoptions, and the confidential intermediary program described in A.R.S. § 8-134.

B. A person who is already knowledgeable about all or part of the matters listed in subsection (A) may waive orientation on those matters, with the approval of the adoption entity. A person may be knowledgeable due to a prior adoption through an Arizona adoption entity, employment in adoption services, or for other similar reasons.

C. An adoption entity shall maintain written documentation showing that any person who has applied to the entity for certification or for placement of a child has received the orientation described in subsection (A), required by R21-9-227, or has obtained a waiver described in subsection (B). If some or all of the adoption orientation is waived, the adoption entity shall document the matters waived and the reasons for the waiver.

D. An adoption entity shall not charge a person for anything other than a certification application fee, or enter into an adoption fee agreement with a person, until the person has received the orientation in subsection (A).

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-404. Application for Certification

An applicant who wishes to become certified as an adoptive parent shall apply for certification as provided in A.R.S. § 8-105. An adoption entity shall require an applicant to provide at least the following information:

1. Personally identifying information for each prospective adoptive parent, including:
   a. Name and date of birth;
   b. Social Security number;
   c. Race and ethnicity;
   d. Physical description;
   e. Current address and duration of Arizona residency;
   f. Marital history; and
   g. The name, address, and phone number of immediate family members, including emancipated adult children;
2. The name, date of birth, and social security number of any person currently residing with the applicant;
3. A listing of the applicant’s insurance policies, including:
   a. Any insurance that may be available to cover the medical expenses of a birth mother or adoptive child; and
   b. The name of the insured, the insurance policy number, and the effective dates of coverage;
4. A current financial statement describing the applicant’s assets, income, debts, and financial obligations;
5. A physician’s statement as to the applicant’s current physical and mental health;
6. A medical and psychological history on the applicant and the applicant’s household members. The history may be a declaration by the applicant of past physical and mental illness for the applicant and any household member;
7. The applicant’s employment history;
8. The applicant’s social history;
9. A statement from the applicant as to the type of child the applicant seeks to adopt and whether the applicant desires to adopt or would consider adopting a child with special needs;
10. Information on the following legal proceedings in which the applicant has been a party:
    a. Dependency proceedings,
    b. Severance or termination of parental rights proceedings,
    c. Child support enforcement proceedings,
    d. Proceedings involving allegations of child abuse or neglect,
    e. Adoption proceedings, or
    f. All criminal proceedings;
11. The applicant’s prior history of adoption certification, including prior applications for certification and the dates of any certification denials;
12. Whether the applicant wishes to be listed on the Adoption Registry;
13. A fingerprint card or fingerprints processed through the Court, meeting the requirements of A.R.S. § 41.1758.07 on each applicant and each adult residing in the home more than the age of 18 years; and
14. The names, addresses, and phone numbers of five personal references; two references from family members related to the applicant by blood or marriage, and three other references, who have known the applicant at least two years and who can attest to the applicant’s character and fitness to adopt.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-405 Certification Investigation
A. Following acceptance of a completed certification application, the adoption entity shall conduct a certification investigation that includes:
1. Personal interviews with the adoptive family. Such interviews shall:
   a. Occur on at least two separate occasions, at least one of which shall be at the adoptive parent’s residence;
   b. Comprise no less than four hours of in person contact, and at least one hour shall take place at the adoptive parent’s residence;
   c. Include at least one separate interview with each member of the adoptive parent’s household who is more than the age of five; and
   d. Include at least one joint interview with both adoptive parents if they are married;
2. Written statements from and personal contact (either a face-to-face meeting or a telephone call) with at least three of the applicant’s personal references;
3. An inquiry as to whether the applicant wishes to be listed in the Adoption Registry;
4. Verification of the applicant’s financial condition through a review of one or more of the documents listed in subsection (A)(7)(g) below;
5. A request to the Department for a check of the Central Registry to determine if the applicant has a past record of substantiated allegations of child abuse or neglect;
6. An evaluation of the success of the placement of other children adopted by the applicant;
7. A review of any supporting documentation the adoption entity reasonably deems necessary to determine an applicant’s fitness to adopt, including:
   a. A physician’s statement regarding the physical health of other adult household members and the applicant’s children living in the home;
   b. A statement from a psychiatrist or psychologist regarding the mental health of the applicant and the applicant’s other household members;
   c. Birth certificates;
   d. Marriage certificate;
   e. Dissolution of marriage or divorce papers and orders, including child support documentation;
   f. Military discharge papers;
   g. Financial statements, tax returns, pay stubs, and W-2 statements;
   h. Bankruptcy papers;
   i. Insurance policy information; and
   j. Documentation showing Arizona residency.
B. A person who meets the qualifications listed in 21 A.A.C. 9, Article 2, shall perform the certification investigation and shall document all personal contacts made and all information reviewed and considered during the investigation.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-406 Certification Report and Recommendation
A. Upon completion of the certification investigation, the adoption entity shall prepare a certification report under A.R.S. § 8-105.
B. In determining whether to recommend certification of an applicant, the adoption entity shall consider all factors bearing on fitness to adopt, including, but not limited to:
   1. The factors listed in A.R.S. § 8-105;
   2. The length and stability of the applicant’s marital relationship, if applicable;
   3. The applicant’s age and health;
   4. Past, significant disturbances, or events in the applicant’s immediate family, such as:
      a. Involuntary job separation;
      b. Divorce, or death of spouse, child, or parent, and
      c. History of child abuse or neglect;
   5. The applicant’s ability to financially provide for an adopted child; and
   6. The applicant’s history of providing financial support to the applicant’s other children, including compliance with court-ordered child support obligations.
C. The certification report shall specifically note any instances where an applicant has:
   1. Been charged with, been convicted of, pled no contest to, or is awaiting trial, on charges of an offense listed in A.R.S. § 41-1758.07; or
   2. Been a party to a dependency, guardianship, or termination of parental rights action.
D. If the report recommends denial of certification, the adoption entity shall send the applicant written notice of the unfavorable recommendation, the reason for the denial, and an explanation of the applicant’s right under A.R.S. § 8-105, to petition the court for review. The adoption entity shall mail the notice to the applicant at least five work days prior to filing the certification report with the Court.
E. The adoption entity may notify the adoptive parent of the Court’s certification decision if the Court fails to do so.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-407 Renewal of Certification
A. A certified adoptive parent who has not filed a petition for adoption within one year of the original certification order, may apply for an extension of certification, as provided in A.R.S. § 8-105.
B. If the Court directs an adoption entity to investigate a certified adoptive parent who has requested a renewal of certification, the entity shall obtain from the adoptive parent seeking renewal:
   1. A copy of the request for renewal of certification;
   2. An updated profile of any changes in the certified adoptive parent’s social, family, medical, and financial circumstances;
   3. New fingerprint clearance per Court requirements, following original certification;
   4. A current physical health statement for all members of the adoptive parent’s household at least every third year following original certification; and
   5. Other information as the Court may request.
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C. When investigating a request for a renewal of certification, the adoption entity shall, at a minimum, complete the following:
1. Conduct an in person interview at the applicant’s home with the applicant and the applicant’s other household members more than the age of five years,
2. Investigate any change in circumstances described in the request for renewal as necessary to determine continuing fitness to adopt, and
3. Document all actions.

D. Upon completion of the renewal investigation, the adoption entity shall prepare and file with the Court a certification investigation that shall contain a recommendation for or against renewal of certification.

E. If the adoption entity recommends that certification not be renewed, the entity shall send the adoptive parent the notice in R21-5-406(D).

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-408. Communication with Adoptive Parents Awaiting Placement
Upon request, an adoption entity shall inform an adoptive parent awaiting placement of a child of the following:
1. The status of the adoptive parent’s case;
2. The number of children the adoption entity currently has available for adoption;
3. The number of times the adoptive parent has been considered for the placement of a child;
4. The number of approved adoptive parents awaiting placement of a child through the adoption entity; and
5. The number of placements the adoption entity made in the prior year, the number of placements the adoption entity has made to date in the current year, and the number of placements the adoption entity anticipates making during the remainder of the current year.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-409. Prohibitions Regarding Birth Parents
An adoption entity shall not:
1. Promise a birth parent that the birth parent shall have future contact with the child or the adoptive parent but may explain the concept of open adoption;
2. Promise a birth parent that the child will be placed with a specific adoptive parent or type of adoptive parent, except in a direct placement adoption. The adoption entity may advise the parent that it will use the entity’s best efforts to honor any placement preferences the birth parent may have, to the extent that such preferences are consistent with the best interests of the child;
3. Promise a birth parent any financial or other consideration prohibited by law; or
4. Do or say anything to coerce or pressure a birth parent to sign a consent to adopt.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-410. Information about Birth Parents
A. Before accepting a child for placement, the adoption entity shall make a good faith effort to obtain the following information described in this Section from the child’s birth parent, or person having custody of the child:
1. Information about each birth parent including:
   a. Name and any aliases used;
   b. Address, phone number, and residential history;
   c. Date and place of birth;
   d. Social security number;
   e. Race, citizenship, and any Native American tribal affiliation or membership;
   f. Physical description;
   g. Name of current employer and employment history;
   h. Educational history;
   i. Marital history and status;
   j. Record of other births and children born to the birth parent;
   k. Hobbies;
   l. Future plans;
   m. Record of arrests or convictions;
   n. Medical, psychological, and substance use history;
   o. For the birth mother, history of prenatal care, gestational substance or drug abuse, pregnancy, and delivery;
   p. Immediate family relationships; and
   q. Significant family events.
2. An explanation of the birth parent’s decision to place the child for adoption, the factors that influenced the decision, and a record of any counseling the birth parent received concerning the decision.
3. A record of the birth parent’s contact with the child.
4. A statement of the birth parent’s feelings about future contact with the child.
5. A list of the birth parent’s preferences regarding an adoptive home for the child.
6. Medical or psychological history on the birth parent’s own parents, siblings, grandparents, aunts, uncles, and first cousins.
7. Information on the child being surrendered for adoption, as appropriate to the age of the child and the child’s:
   a. Developmental history,
   b. Medical and psychological history,
   c. Family background,
   d. Educational history, and
   e. Membership in or affiliation with any Native American tribe.
8. A listing of the birth parent’s insurance policies, including:
   a. Any insurance that may be available to cover the medical expenses of the birth mother or adoptive child; and
   b. The name of the insured, the insurance policy number, and the effective dates of coverage.

B. The adoption entity shall document all statements and information in a permanent record.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-411. Pre-consent Conference with Birth Parents
A. The adoption entity shall have a pre-consent conference with each birth parent who must provide consent to adoption under A.R.S. § 8-106, to explain in a language and form that each birth parent can understand the following:
1. The legal and practical consequences of executing a consent, including:
   a. Applicable ICWA provisions; and
   b. The fact that the consent, and all other affidavits executed in connection with an adoption, are executed under penalty of perjury;
2. The irreversibility and irrevocability of a consent;
3. The legal prohibition against paying the birth parent to execute a consent;
4. The fact that the birth parent has no obligation to sign the consent; and
5. The provisions of A.R.S. § 8-106, regarding an affidavit of any potential father.

B. The pre-consent conference shall occur:
1. No earlier than 12 hours after the birth of a child if the conference was not held before the birth under subsection (B)(2);
2. No earlier than 60 days before the anticipated due date, if the conference is held before the child’s birth;
3. At least 24 hours before presenting a birth parent with the consent form for signature; and
4. At a time that takes into account the known medical and emotional condition of each available birth parent.

C. The person conducting the pre-consent conference shall provide the birth parent with a sample consent form and shall convey the information described in subsection (A) in a language and form that the birth parent can understand.

D. The person conducting the pre-consent conference shall document that the information was given and understood and shall obtain the birth parent’s signature on the documentation. If the conference is by telephone under subsection (E), the person may obtain the signature through the mail at a later date. If the conference is not held, the person shall document the reason under subsection (E).

E. The pre-consent conference may be by telephone and is not required if the birth parent cannot be located or refuses to participate in the conference. The adoption entity shall document the reason why the conference did not occur.

F. If required to obtain a consent from a birth father under A.R.S. § 8-106, the adoption entity shall, prior to obtaining the birth father’s signature, advise the birth father of the matters listed in subsection (A) in a form and language the birth father can understand. The adoption entity shall include the advice listed in subsection (A) on the consent form.

Historical Note
New Section made by final exempt rulemaking at 21 A.R.S. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-413. Adoptable Child: Assessment and Service Plan
A. Prior to selecting an adoptive placement for an adoptable child, the adoption entity shall:
1. Assess the child’s medical, psychological, social, and developmental needs;
2. Design an adoptive family profile consistent with the child’s needs and best interests;
3. Develop a written service plan; and
4. Assess whether the child is a potential candidate for an adoption subsidy.

B. The service plan shall, at a minimum, include:
1. Placing the child on the Adoption Registry if there is no adoptive parent readily available to adopt the child;
2. Giving the child a developmentally appropriate explanation of the adoption process.

C. The adoption entity shall provide the child with services in accordance with the child’s service plan.

Historical Note
New Section made by final exempt rulemaking at 21 A.R.S. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-414. Placement Determination
A. An adoption entity shall have and follow a written policy for making placement recommendations and decisions in both direct placement and adoption placement adoptions.

B. Except as otherwise provided in subsection (C), in an agency placement adoption a team shall make the placement decision. The team shall at a minimum, include:
1. The case manager or person who assessed the adoptable child, and
2. The case manager or person who is knowledgeable about the potential adoptive parents for the adoptable child.

C. In international adoptions, where the case manager or person who assessed the child is out of the country and unavailable, the adoption team shall include the person who is most familiar with the adoptable child’s needs.

D. In an agency placement adoption, an adoption entity shall place an adoptable child in the adoptive setting that best meets the child’s safety, social, emotional, physical and mental health needs. In determining who can best meet the needs, the adoption entity shall consider ICWA placement preferences if applicable and the following relevant factors in no order of preference:
1. The marital status, length and stability of the marital relationship of the adoptive parent;
2. The family’s ability to meet the child’s emotional, physical, mental, and social needs;
3. The family’s ability to financially provide for the child;
4. The wishes of a child who is 12 years of age or more;
5. Family relationships between the child and the adoptive parent’s family members;
6. The placement of the child’s siblings;
7. The availability of relatives, the adoptable child’s former foster parents, or other significant persons to provide support to the adoptive parent and child;
8. The wishes of the child’s birth parent; and
9. All information in the case files of the child and the adoptive parent.

E. The adoption entity shall document the placement decision.
1. For adoptions conducted pursuant to the ICPC, the documentation shall comply with the requirements of the ICPC under A.R.S. § 8-548 et seq.
2. For all other adoptions, the documentation shall include the following:
   a. The adoptive child’s critical needs and characteristics that weigh most heavily in the placement determination,
   b. The names and general characteristics of those adoptive parents who most closely match the child’s needs and who are seriously considered for placement, and
   c. The reasons why a particular adoptive parent chosen for placement best meets the child’s needs.

F. For adoptions not covered by the ICPC, the adoption entity may document the placement decision in a file or placement log that is separate from the clients’ case files.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-415. Provision of Information on a Placed Child
After selecting an adoptive placement for a child, and before placing the child with the chosen adoptive parent, the adoption entity shall provide the adoptive parent with all non-identifying information available on the child, including, without limitation, the following:
1. All records concerning the child’s medical, psychological, social, legal, family, and educational background;
2. All records concerning the birth parents’ medical, psychological, social, legal, family, and educational background;
3. The medical and social background on the child’s other immediate family members, including siblings and birth grandparents;
4. The child’s plan for adoption services, as described in R21-4-413; and
5. Information on adoption subsidy that may be available for the child.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-4-416. Transportation
An adoption entity that transports an adoptive child shall:
1. Ensure that any person who transports an adoptive child is informed of the child’s medical needs and is capable of meeting any medical needs that are reasonably likely to arise during transport;
2. Not leave an adoptive child unattended during transportation if the adoptive child:
   a. Is less than seven years of age;
   b. Has a developmental disability; and
   c. Is more than seven years of age if the adoption entity has determined, and documented in the child’s record, that the child is physically and emotionally incapable of traveling alone;
3. Require all persons who provide transport to carry personal identification and a written statement from the adoption entity describing the person’s authority and responsibilities while performing transport duties;
4. Require proof of driver’s license from any person accepting temporary or permanent responsibility for transporting an adoptive child during the course of placement;
5. Document all transportation plans and actual transportation events in the child’s record;
6. All vehicles used in transporting adoptive children shall be insured;
7. Ensure that an adoptive child is properly secured in a child restraint system that meets the requirements listed in R21-9-224(E).

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-417. Placement Services
A. An adoption entity shall make counseling services available to the adoptive parents’ family as the entity deems reasonable and necessary to facilitate the child’s acceptance into the adoptive parent’s family and to preserve stability. The adoption entity may make such services available by advising the adoptive family that such services may be beneficial and referring the adoptive parent and his or her family to community resources and providers.
B. The adoption entity shall make information on adoption related educational and supportive resources available to adoptive parents.
C. The adoptive parent must sign a document stating if he or she is declining any form of adoption counseling.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-418. Post-placement Supervision: Non-foster Parent Placement
A. When a child is placed for adoption with a person who is not the child’s foster parent, a case manager from the adoption entity shall visit the home within 30 calendar days of the date of adoptive placement to:
1. Ensure that the adoptive parent received all available non-identifying information from the adoption entity on the child;
2. Address any questions or concerns the adoptive parent or child may have about the adoption process or placement;
3. Ensure that the family has addressed the educational needs of a school-age child; and
4. Ensure that an adoptive parent who works has made appropriate child care arrangements.

B. Following the initial placement visit in subsection (A), a case manager from the adoption entity shall:
1. Visit the adoptive family at least once every three months until the adoption is finalized:
   a. Except, when the adoptive child is a child with special needs, the visits shall occur at least once a month; and
   b. During the first six months following the initial placement visit, at least alternating visits shall occur at the adoptive family’s home;
2. Interview all members of the adoptive family’s household during the placement supervision period;
3. Discuss how the child and the adoptive parent’s family are adapting, the current relationship among members of the adoptive parent's family, and the following issues with the adoptive parent if appropriate in light of the child's age and development:
   a. How the presence of the child has changed familial relationships;
   b. How the child and the extended family view each other;
   c. The role each family member has assumed regarding child care and discipline;
   d. How the adoptive parent is coping with the needs and demands of the placed child;
   e. How the child challenges or tests the placement and how the family reacts to these episodes, including any feelings of insecurity about the propriety of the family members’ response;
   f. How the family perceives the child’s sense of identity and the need to fill in gaps in the child’s history; and
   g. How the child has adjusted to the school environment;
   4. If developmentally appropriate, privately interview the child about:
      a. The child’s feelings about the adoption;
      b. How the child and family are adapting; and
      c. The child’s relationships with the members of the family.
   C. The case manager shall document all contacts and communications made under this Section.

   Historical Note
   New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-420. Protracted Placement
If an adoption is not finalized within two years from the date of consent, and the child is still placed in the adoptive home, the adoption entity handling the adoption shall provide the Department with written documentation explaining the reason why the adoption has not been finalized, no later than 30 calendar days after the two-year period has ended.

   Historical Note
   New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-421. Finalizing the Placement
An adoption entity shall cooperate with the adoptive parent and the attorney, if any, retained by the adoptive parent, to finalize the adoption.
   1. The entity shall provide all information and documents needed to finalize the adoption and shall file a final written report to the court at least 14 calendar days before the final adoption hearing, or at such other time as the Court may require. The report shall include the information listed in this subsection, unless the entity has already provided this information in an earlier report, and the information has not changed since the earlier report.
      a. The name and age of each adoptive parent and the relationship, if any, of each adoptive parent to the child to be adopted;
      b. The name, age, and birthplace of the child to be adopted, and whether any or all of this information is unknown to the adoptive parent;
      c. The entity or other source from which the adoptive parent received the child to be adopted;
      d. The circumstances surrounding the surrender of the child to the entity;
      e. The results of the entity’s evaluation of the child and of the adoptive parent, including:
         i. A description of the care the child is receiving;
         ii. The adjustment of the child and parent; and
         iii. A summary statement of the entity’s recommendation to the court regarding finalization;
      f. A full description of any property belonging to the child to be adopted;
   2. For children 12 years of age and older, the adoption entity shall solicit and consider the child’s wishes concerning adoption.
   3. The adoption entity shall notify the AHCCCS Administration of any potential third party payor, as prescribed in A.R.S. § 36-2946, if the entity has not already done so.

   Historical Note
   New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-422. Placement Disruption
A. When a placement fails, the adoption entity shall provide services, including counseling to the adoptive parent and his or her family and child, to help them cope with the loss and separation.
B. An adoption entity shall have and follow written procedures for an adoptive placement disruption. The procedures shall include:
   1. Provision of counseling services to the adoptive parent, his or her family, and the child as needed; and
   2. Provision for placement of the child in another adoptive home or other developmentally appropriate living arrangement.
C. The adoptive entity shall document the reasons for the disruption and shall take such information into account when making future placements for the adoptive parent and the child.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

R21-5-423. Confidentiality
Any person or entity who participates in an adoption or provides adoption services shall comply with the confidentiality requirements under A.R.S. §§ 8-120, 8-121, and 36-2903.01.

Historical Note
New Section made by final exempt rulemaking at 21 A.A.R. 3255, effective January 24, 2016 (Supp. 15-4).

ARTICLE 5. ADOPTION SUBSIDY

R21-5-501. Definitions
In addition to the definitions in A.R.S. §§ 8-141 and 8-501, the following definitions apply in this Article.

1. “Adoption agency” means an individual or entity, including a corporation, company, partnership, firm, association, or society, other than the Department, licensed by the Department to place a child for adoption.
2. “Adoption Specialist” means the Department of Child Safety Specialist, or adoption agency staff person, who is responsible for managing the child’s case prior to the adoption finalization.
3. “Adoption subsidy” means the same as A.R.S. § 8-141, and includes nonrecurring adoption expenses under A.R.S. § 8-161 et seq. If the child qualifies, the adoption subsidy may include one or more of the following:
   a. Medical, dental, and mental health subsidy;
   b. Maintenance subsidy;
   c. Special services subsidy; and
   d. Reimbursement of nonrecurring adoption expenses.
4. “Adoption subsidy agreement” means the agreement in A.R.S. § 8-144 concerning the Adoption Subsidy Program and includes the agreement in A.R.S. § 8-162 concerning the nonrecurring adoption expense program.
5. “Adoption Subsidy Program” means a unit within the Department of Child Safety that administers the adoption subsidy.
6. “Adoption Subsidy Supervisor” means a Department employee who is responsible for the Adoption Subsidy Program within a defined geographic area, and that the Department has authorized to approve an adoption subsidy agreement.
7. “Adoptive parent” means an adult who has been certified or approved to adopt a child, or an adult who has adopted a child.
8. “AHCCCS” means the Arizona Health Care Cost Containment System, which is the state’s program for medical assistance available under Title XIX of the Social Security Act and state public insurance statutes, A.R.S. Title 36, Chapter 29.
9. “AHCCCS hospital reimbursement system” means the payment system that AHCCCS uses to pay for inpatient and outpatient hospital services.
10. “Complete adoption subsidy application” means a packet containing the following:
   a. An “Adoptive Family Subsidy Application” form provided by the Department that the adoptive parent, the Adoption Specialist, and Adoption Specialist supervisor have completed and signed; and
   b. The supporting documentation and information requested in the “Adoptive Family Subsidy Application.”
11. “Debilitating” means a lifelong, progressive, or fatal condition characterized by physical, mental, or developmental impairment that impedes an individual’s ability to function independently.
12. “Department” or “DCS” means the Arizona Department of Child Safety.
14. “Diagnose” means to identify a physical, psychological, social, learning, or developmental condition or disability according to the accepted standards of the medical, mental health, or educational professions.
15. “Emergency situation” means a circumstance that, if unaddressed, would be detrimental to a child’s life, health, or safety.
16. “Emotional disturbance” means the same as A.R.S. § 8-141.
17. “Lawfully present in the United States” means the child is a U.S. citizen, national, or an alien authorized by an appropriate federal entity or court to be present in the United States.
18. “Legally free” means the parental rights of a child’s birth or legal parents have been terminated.
19. “Maintenance subsidy” means a monthly payment paid to a custodial adoptive parent to assist with the costs directly related to meeting some of the adopted child’s needs, including child care, health insurance co-payments and deductibles, and supplemental educational services for the adopted child.
20. “Mental disability” means the same as A.R.S. § 8-141.
21. “Nonrecurring adoption expenses” means the same as A.R.S. § 8-161, and are reasonable and necessary expenses directly related to the legal process of adopting a child with special needs. Allowable expenses include adoption fees, court costs, attorney’s fees, fingerprinting fees, home study fees, costs for physical and psychological examinations, costs for placement supervision, and travel expenses necessary to complete the adoption.
22. “Physical disability” means the same as A.R.S. § 8-141.
23. “Qualified professional” means a practitioner licensed or certified by the state of Arizona or another state to evaluate and diagnose a condition or disability, or provide medical, dental, mental health services, or approved by the Department to provide educational or respite services.
24. “Sibling relationship” means two or more brothers or sisters who are related by blood or by law, and who are being adopted by the same family.
25. “Special allowance” means funds provided for clothing or personal expenses, therapeutic or personal attendant care, and other specialized payments such as emergency clothing, education, and gift allowances.
26. “Special needs” means one or more of the following conditions which existed before the finalization of adoption:
   a. Physical, mental or developmental disability.
   b. Emotional disturbance.
   c. High risk of physical or mental disease.
   d. High risk of developmental disability.
   e. Age of six or more years at the time of application for an adoption subsidy.
   f. Sibling relationship.
   g. Racial or ethnic factors.
   h. High risk of severe emotional disturbance if removed from the care of his foster parents.
8-105. Preadoption certification; investigation; central adoption registry

A. Before any prospective adoptive parent may petition to adopt a child the person shall be certified by the court as acceptable to adopt children. A certificate shall be issued only after an investigation conducted by an officer of the court, by an agency, by the department or by an entity contracted by the department to do an investigation and home study for foster home licensing or preadoption certification. A written application for certification shall be made directly to the court, to an agency, to the department or to an entity contracted by the department, in the form and content required by the court, agency or department.

B. The department is not required to accept every application for certification. In determining which applications to accept the department may give priority to applications filed by adult residents of this state who wish to adopt a child who has any special needs as defined in section 8-141.

C. After receiving and accepting the written and completed application of the prospective adoptive parent or parents, which shall include a financial statement and a physician's or a registered nurse practitioner's statement of each applicant's physical health, the department, the agency, an officer of the court or the entity contracted by the department shall conduct or cause to be conducted an investigation of the prospective adoptive parent or parents to determine if they are fit and proper persons to adopt children.

D. The department shall not present for certification a prospective adoptive parent unless that person and each other adult member of the household have a valid fingerprint clearance card issued pursuant to section 41-1758.07. The prospective adoptive parent and each other adult member of the household must certify on forms that are provided by the department and that are notarized whether that person is awaiting trial on or has ever been convicted of any of the criminal offenses listed in section 41-1758.07, subsections B and C in this state or similar offenses in another state or jurisdiction.

E. An officer of the court may obtain a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

F. This investigation and report to the court shall consider all relevant and material facts dealing with the prospective adoptive parents' fitness to adopt children and shall include:

1. A complete social history.

2. The financial condition of the applicant.

3. The moral fitness of the applicant.

4. The religious background of the applicant.

5. The physical and mental health condition of the applicants.

6. Any court action for or adjudication of child abuse, abandonment of children, dependency or termination of parent-child relationship in which the applicant had control, care or custody of the child who was the subject of the action.

7. Whether the person or persons wish to be placed on the central registry established in subsection M of this section.

8. All other facts bearing on the issue of the fitness of the prospective adoptive parents that the court, agency or department may deem relevant.

G. The investigator shall not reveal to the prospective adoptive parents the identity of a child or the child's parent or parents and shall not reveal to the child or the child's parent or parents the identity of the prospective adoptive
parents if these facts are not already known.

H. Within ninety days after the original application prescribed by subsection A of this section has been accepted, the department, the agency or the entity contracted by the department or a person or agency designated by the court to conduct an investigation shall present to the juvenile court the written report required by subsection F of this section, which shall include a definite recommendation for certifying the applicant as being acceptable or nonacceptable to adopt children and the reasons for the recommendation.

I. Within sixty days after receiving the investigation report required by subsections F and H of this section, the court shall certify the applicant as being acceptable or nonacceptable to adopt children based on the investigation report and recommendations of the report. A certification remains in effect for eighteen months from the date of its issuance and may be extended for additional one year periods if after review the court finds that there have been no material changes in circumstances that would adversely affect the acceptability of the applicant to adopt.

J. The court may require additional investigation if it finds that additional information is necessary on which to make an appropriate decision regarding certification.

K. Any applicant who has been certified as nonacceptable may petition the court to review that certification. Notice shall be given to all interested parties and notice may be given to the foster care review board if the child sought to be adopted is in out-of-home placement and is a dependent child or the subject of a dependency action. The matter shall be heard by the court, which may affirm or reverse the certification.

L. If the applicant is certified as nonacceptable, the applicant may not reapply for certification to the court, to any agency, to the department or to an entity contracted by the department for one year.

M. The department shall maintain a central adoption registry that includes the names of all prospective adoptive parents currently certified by the court as acceptable to adopt children, except those who request that their names not be included, the names of all children who are under the jurisdiction of the department and who are currently available for adoption, the names of any other children who are currently available for adoption and whose names are voluntarily entered in the registry by any agency, parent or other person that has the right to give consent to the child's adoption, and other information as the department may elect to include in aid of adoptive placements. Access to information in the registry shall be made available on request to any agency under assurances as the department may require that the information sought is in furtherance of adoptive placements and that confidentiality of the information is preserved.

N. This section does not apply if:

1. The prospective adoptive parent is the spouse of the birth or legal parent of the child to be adopted or is an uncle, aunt, adult sibling, grandparent or great-grandparent of the child of the whole or half-blood or by marriage or adoption.

2. The birth or legal parent is deceased but at the time of death the parent had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the birth or legal parent during the twenty-four months before the death of the parent.

3. The grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling is deceased but at the time of death that person had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling during the twenty-four months before the death of the grandparent, great-grandparent, uncle, aunt, great-uncle, great-aunt or adult sibling.

4. The applicant is a licensed foster parent who is petitioning to adopt a child currently placed by the department in the foster parent's home and the department recommends the adoption of the child by the foster parent applicant.
O. If the applicant is not a licensed foster parent and has adopted a child within three years preceding the current application and is applying to adopt another child, the department, the agency or an entity contracted by the department or a person designated by the court to conduct an investigation shall only provide an update report on any changes in circumstances that have occurred since the previous certification. If the applicant has adopted a child more than three years before the current application and is applying to adopt another child, the department, the agency or an entity contracted by the department or a person designated by the court to conduct an investigation may provide an updated report on any changes in circumstances that have occurred since the previous certification. The court shall certify the applicant as acceptable to adopt unless there are changes in circumstances that adversely affect the applicant's parenting ability. In making this determination, the court shall consider information from the prior certification.
8-106. Consent to adoption; waiver; consent to the release of information; notification to potential fathers

A. The court shall not grant an adoption of a child unless consent to adopt has been obtained and filed with the court from the following:

1. The child's birth or adoptive mother, if living.

2. The child's father if any of the following is true:

   (a) The father was married to the child's mother at the time of conception or at any time between conception and the child's birth unless his paternity is excluded or another man's paternity is established pursuant to title 25, chapter 6, article 1.

   (b) The father has adopted the child.

   (c) The father's paternity is established under title 25, chapter 6, article 1 or section 36-334.

3. A child who is twelve years of age or older and who gives consent in open court.

4. Any guardian of the person of the child who is appointed by a court and who is given authority by it to consent to the child's adoption.

5. An agency that has been given consent to place the child for adoption by the parent or parents whose consent would be necessary under paragraph 1 or 2 of this subsection, or that has been given authority in other legal proceedings to place the child for adoption.

6. The guardian of any adult parent for whom a guardian is currently appointed.

7. The division if it has been given consent to place the child for adoption by the parent or parents whose consent would otherwise be necessary pursuant to paragraph 1 or 2 of this subsection or if it has been given authority in other legal proceedings to place the child for adoption. The court may waive the requirement for consent if the court determines, after a hearing on actual notice to all persons who may be adversely affected, that waiving the requirement is clearly in the child's best interest.

B. It is not necessary for a person to obtain consent to adopt from the following:

1. An adult parent for whom a guardian is currently appointed.

2. A parent whose parental rights have been terminated by court order.

3. A parent who has previously consented to an agency's or the division's placement of the child for adoption.

4. A person whose consent is not required under subsection A of this section.

C. The minority of the child or parent does not affect the child's or parent's competency to give consent in the instances set forth in this section.

D. A consent to adopt is irrevocable unless obtained by fraud, duress or undue influence.

E. An agency, the division or an attorney participating or assisting in a direct placement adoption pursuant to section 8-130 shall obtain from a birth parent, at the time consent for adoption is obtained, a notarized statement that acknowledges that when the child being adopted reaches eighteen years of age, the child may obtain a copy of the child's original birth certificate as provided in section 36-340. The birth parent shall also submit the contact preference form prescribed in section 36-340 to the agency, division or attorney for filing with the court.
F. A notarized affidavit signed by the mother listing all potential fathers shall be filed with the court. The affidavit shall attest that all of the information contained in the affidavit is complete and accurate.

G. Notice shall be served on each potential father as provided for the service of process in civil actions. The notice shall be substantially in the form prescribed in subsection I of this section and shall inform the potential father of all of the following:

1. That adoption is planned.

2. The potential father's right to consent or withhold consent to the adoption.

3. The potential father's responsibility to initiate paternity proceedings under title 25, chapter 6, article 1, and to serve the mother within thirty days of completion of service.

4. The potential father's responsibility to proceed to judgment in the paternity action.

5. The potential father's right to seek custody.

6. The potential father's responsibility to begin to provide financial support for the child if paternity is established.

7. That the potential father's failure to file a paternity action pursuant to title 25, chapter 6, article 1, and to serve the mother and proceed to judgment in the paternity action as prescribed by this section, bars the potential father from bringing or maintaining any action to assert any interest in the child.

H. Service on a mother of a title 25, chapter 6, article 1 paternity action pursuant to this section may be accepted by an attorney or agency that is licensed in this state and that is representing the mother. A mother may omit her address from the affidavit and notice to potential fathers if the address of her attorney or the agency is provided in the affidavit. Service on an attorney or agency pursuant to this subsection is limited to service of the initial verified petition and summons in the paternity action. Service on the attorney does not make the attorney the attorney of record for the mother in the paternity action and does not make the agency the agent for the mother in the paternity action.

I. The notice required pursuant to subsection G of this section shall be in substantially the following form:

Notice:

Notice is given to _______________ that you have been identified by ____________________, the natural mother, as a potential father of a child to be born or, born on _____________, in ________.

You are informed of the following:

1. ______________, the natural mother, plans to place the child for adoption.

2. Under sections 8-106 and 8-107, Arizona Revised Statutes, you have the right to consent or withhold consent to the adoption.

3. Your written consent to the adoption is irrevocable once you give it.

4. If you withhold consent to the adoption, you must initiate paternity proceedings under title 25, chapter 6, article 1, Arizona Revised Statutes, and serve the mother within thirty days after completion of service of this notice.

5. You have the obligation to proceed to judgment in the paternity action.

6. You have the right to seek custody.
7. If you are established as the child's father, you must begin to provide financial support for the child.

8. If you do not file a paternity action under title 25, chapter 6, article 1, Arizona Revised Statutes, and do not serve the mother within thirty days after completion of the service of this notice and pursue the action to judgment, you cannot bring or maintain any action to assert any interest in the child.

9. The Indian child welfare act may supersede the Arizona Revised Statutes regarding adoption and paternity.

10. For the purposes of service of a paternity action under title 25, chapter 6, article 1, Arizona Revised Statutes, service may be made on the mother at ____________ or her agency or attorney at ____________.

11. You may wish to consult with an attorney to assist you in responding to this notice.

J. A potential father who fails to file a paternity action and who does not serve the mother within thirty days after completion of service on the potential father as prescribed in subsection G of this section waives his right to be notified of any judicial hearing regarding the child's adoption or the termination of parental rights and his consent to the adoption or termination is not required.
8-112. Social studies; requirements

A. The division, an agency or an officer of the court shall conduct and submit a social study to the court ten days before the hearing on the petition to adopt. Notwithstanding any other provisions of this section, the court may order an additional social study or waive the social study if it determines that this is in the child's best interests because of special circumstances.

B. Except as provided in subsection D or E of this section, the social study shall include the following:

1. The social history, heritage and mental and physical condition of the child and the child's birth parents.

2. The child's current placement in the prospective adoptive parent's home and the child's adjustment to that home.

3. The prospective adoptive parent's suitability to adopt.

4. The existing and proposed arrangements regarding the child's custody.

5. Any financial arrangement concerning the proposed adoption made by the birth parents, the division, an agency, an attorney or the prospective adoptive parents.

6. A state and federal criminal records check of the prospective adoptive parent and each adult who is living permanently with the prospective adoptive parent except a birth or legal parent with custody of the child. A valid fingerprint clearance card that is issued pursuant to section 41-1758.07 satisfies this requirement. The court may order an additional state and federal criminal records check for good cause.

7. A central registry records check, including any history of child welfare referrals, with the division of the prospective adoptive parent and each adult who is living permanently with the prospective adoptive parent.

8. Any other information that is pertinent to the adoption proceedings.

C. The social study conducted pursuant to subsection A of this section is part of the case file and shall contain a definite recommendation for or against the proposed adoption and the reasons for that recommendation.

D. The social study conducted pursuant to subsection A of this section shall consist only of the results of the state and federal criminal records check and the central registry records check conducted pursuant to subsection B of this section if either of the following is true:

1. The prospective adoptive parent is the child's stepparent who has been legally married to the child's birth or legal parent for at least one year and the child has resided with the stepparent and parent for at least six months.

2. The prospective adoptive parent is the child's adult sibling, by the whole or half blood, or the child's aunt, uncle, grandparent or great-grandparent and the child has resided with the prospective adoptive parent for at least six months.

E. If the child being considered for adoption has resided with the prospective adoptive parent for at least six months and the prospective adoptive parent either has adopted a child or was appointed the permanent guardian of the child within three years preceding the current application, or is a foster parent who is licensed by this state, the social study conducted pursuant to subsection A of this section may consist only of the following:

1. The results of the central registry records check conducted pursuant to subsection B of this section.

2. A review of any material changes in circumstances that have occurred since the previous adoption, permanent guardianship or license renewal that affect the prospective adoptive parent's ability to adopt the child or for the child to be placed in the prospective adoptive parent's home.
F. The department shall complete any required social study within six months after receiving a completed application to adopt a child if all of the following apply to the child:

1. The child is free for adoption and is at least sixteen years of age.

2. The department has placed the child with a prospective adoptive parent.

3. The child consents to the adoption.
8-120. Records; inspection; exception; destruction or transfer of certain records

A. Except as provided in section 8-129, all files, records, reports and other papers compiled under this article, whether filed in or in possession of the court, an agency or any person or association, shall be withheld from public inspection.

B. Such files, records, reports and other papers may be open to inspection by persons and agencies having a legitimate interest in the case and their attorneys and by other persons and agencies having a legitimate interest in the protection, welfare or treatment of the child if so ordered by the court.

C. This section does not prohibit persons employed by the court, the division or an agency from conducting the investigations or performing other duties pursuant to this article within the normal course of their employment.

D. This section does not prohibit persons employed by the court, the division, an attorney participating or assisting in a direct placement adoption pursuant to section 8-130 or an agency from providing partial or complete identifying information between a birth parent and adoptive parent when the parties mutually agree to share specific identifying information and make a written request to the court, the division or the agency.

E. Except for files that belong to an attorney, all files, records, reports and other papers not filed in or in the possession of the court shall not be destroyed until after a ninety-nine year period. The files that belong to an attorney shall not be destroyed until after a seven-year period.

F. If an adoption agency ceases operations, the adoption agency shall do all of the following:

1. Transfer the documents described in subsection A of this section to the division or to another adoption agency in this state if the documents concern a matter that is closed.

2. Transfer the documents described in subsection A of this section to another adoption agency in this state if the documents concern a matter that is open.

3. Notify the division of the transfer of any documents to another adoption agency in this state pursuant to this subsection.

4. Notify all adoptive parents whose files it is transferring pursuant to this subsection of the transfer.
8-129. Health and genetic history; compilation; availability; costs

A. Before placing a child for adoption, the division or the agency or the person placing the child, if the child is not placed by the division, shall compile and provide to the prospective adoptive parents detailed written nonidentifying information, including a health and genetic history and all nonidentifying information about the birth parents or members of a birth parent's family set forth in a document that is separate from any document containing identifying information. This subsection does not apply if the birth parents are deceased, their whereabouts are unknown or the information is not otherwise reasonably available.

B. Records containing the information prescribed in subsection A of this section:

1. Shall be retained by the division, agency or person placing the child for ninety-nine years, and if an agency or person ceases to function, the agency or person shall transfer these records to the division, except that an agency ceasing operations may transfer these records to another agency within this state, provided the agency transferring the records gives notice of the transfer to the division.

2. May be supplemented with information supplied by any member of the birth family, any member of the adoptive family, an adult adoptee or the family of an adult adoptee. Supplemental information supplied to the division or the agency or the person who placed the child shall be filed with all other information concerning the adoption. The division, agency or person placing the child shall notify the adoptee, if the adoptee is at least eighteen years of age, or the adoptive parents, if the adoptee is under eighteen years of age, of the receipt of any supplemental information from a member of the birth family.

3. Shall be available on request throughout the ninety-nine year period, together with any other information described in subsection A of this section which is added, to the following persons only:

(a) The adoptive parents of the child or, if the adoptive parents have died, the child's guardian.

(b) The adoptee if the adoptee is eighteen years of age or more, including a qualified young adult who was previously adopted and who is participating in a program described in section 8-521, 8-521.01 or 8-521.02.

(c) If the adoptee has died, the adoptee's spouse if the spouse is the legal parent of the adoptee's child or the guardian of any child of the adoptee.

(d) If the adoptee has died, any progeny of the adoptee who is eighteen years of age or more.

(e) The birth parent of the adoptee or other biological children of the birth parent.

C. The actual and reasonable cost of providing information pursuant to this section shall be paid by the person requesting the information.
8-130. Consent to licensed agency or division; attorneys; affidavits

A. A consent to adoption of a child shall not be granted to an agency unless the agency is licensed to place children for adoption under this article. A consent may be granted to the division, which is exempt from licensure. An agency or the division may conduct both agency placement adoptions and direct placement adoptions. An agency placement adoption shall only be made by an agency or the division.

B. Except as provided in subsection C, a person shall not do any of the following unless the person is employed or engaged by and acting on behalf of a licensed adoption agency:

1. Solicit or accept employment or engagement, for compensation, by or on behalf of a parent or guardian for assistance in the placement of a child for adoption.

2. Solicit or accept employment or engagement, for compensation, by or on behalf of any person to locate or obtain a child for adoption.

C. An attorney licensed to practice law in this state may assist and participate in direct placement adoptions and may receive compensation to the extent the court finds reasonable under section 8-114 if the person granting consent to the adoption has made a choice of the specific adopting parent without prior involvement of the attorney or if the choice is made only from among persons currently certified by the court as acceptable to adopt children pursuant to section 8-105.

D. Before a petition to adopt is granted and as a condition of the entry of an order of adoption:

1. An attorney participating or assisting in a direct placement adoption shall file with the court an affidavit confirming that there has been, to the best of his knowledge and belief, compliance with subsection B of this section and with section 8-114, subsection B, section 8-129 and, if fictitious names have been used, section 8-107, subsection E.

2. An attorney representing petitioners in an agency placement adoption and the agency shall file with the court an affidavit confirming that there has been, to the best of the petitioner's, agency's and attorney's knowledge and belief, compliance with subsections A and B of this section and sections 8-114 and 8-129.
8-171. Definitions

In this article, unless the context otherwise requires:

1. "Adoption assistance" means payments, medical assistance or benefits provided by an adoption assistance state pursuant to applicable federal and state laws.

2. "Adoption assistance state" means a state that is a signatory to an interstate adoption assistance compact.

3. "State" means a state, district, commonwealth or territory of the United States.
8-172. Interstate compacts; requirements; optional contents

The department may enter into a compact with other states to provide for the reciprocal enforcement of adoption assistance agreements. A compact entered into pursuant to this section shall contain the following:

1. A provision making it available for joinder by all states.

2. A provision or provisions for withdrawal from the compact on written notice to the parties no sooner than one year from the date of the notice.

3. A requirement that the protections afforded by or pursuant to the compact continue in force for the duration of the adoption assistance and are applicable to all children and their adoptive parents who on the effective date of the state's withdrawal from the compact are receiving adoption assistance from a party state other than the one in which they are residents and have their principal place of abode.

4. A requirement that each instance of adoption assistance to which the compact applies is covered by an adoption assistance agreement in writing between the adoptive parents and the state child welfare agency of the state that provides the adoption assistance and that this agreement is expressly for the benefit of the adopted child and is enforceable by the adoptive parents and the state agency providing the adoption assistance.

5. Other provisions necessary to implement the compact.
8-173. Adoption assistance agreements; reciprocity conditions; violation; classification

A. A child who resides in this state and who is the subject of an adoption assistance agreement with a state that has entered into a compact with this state is entitled to receive medical assistance from this state if the adoption assistance agreement provides categorical eligibility for federally funded medical assistance. This entitlement begins on the filing with the department of a certified copy of the adoption assistance agreement obtained from the adoption assistance state. In accordance with department rules, the adoptive parents shall show at least annually that the agreement with the other adoption assistance state is still in force or has been renewed.

B. The department and the Arizona health care cost containment system administration shall consider the holder of an adoption assistance agreement, as provided in subsection A of this section, as any other eligible medical assistance person under the laws of this state and shall make medical assistance payments pursuant to the same conditions and procedures for other recipients of medical assistance.

C. A person who knowingly submits a claim for payment or reimbursement for services or benefits pursuant to this section or who makes a statement in connection with a claim that is false, misleading or fraudulent is guilty of a class 6 felony.
8-453. **Powers and duties**

A. The director shall:

1. Carry out the purposes of the department prescribed in section 8-451.

2. Provide transparency by being open and accountable to the public for the actions of the department.

3. Develop a data system that enables persons and entities that are charged with a responsibility relating to child safety to access all relevant information relating to an abused, neglected or abandoned child as provided by law.

4. Subject to title 41, chapter 4, article 4 and, as applicable, articles 5 and 6, employ deputy directors and other key personnel based on qualifications that are prescribed by the director.

5. Adopt rules to implement the purposes of the department and the duties and powers of the director.

6. Petition, as necessary to implement the case plan established under section 8-824 or 8-845, for the appointment of a guardian or a temporary guardian under title 14, chapter 5 for children who are in custody of the department pursuant to court order. Persons applying to be guardians or temporary guardians under this section shall be fingerprinted. A foster parent or certified adoptive parent already fingerprinted is not required to be fingerprinted again, if the foster parent or certified adoptive parent is the person applying to be the guardian or temporary guardian.

7. Cooperate with other agencies of this state, county and municipal agencies, faith-based organizations and community social services agencies, if available, to achieve the purposes of this chapter.

8. Exchange information, including case specific information, and cooperate with the department of economic security for the administration of the department of economic security's programs.

9. Administer child welfare activities, including:

   (a) Cross-jurisdictional placements pursuant to section 8-548.

   (b) Providing the cost of care of:

      (i) Children who are in temporary custody, are the subject of a dependency petition or are adjudicated by the court as dependent and who are in out-of-home placement, except state institutions.

      (ii) Children who are voluntarily placed in out-of-home placement pursuant to section 8-806.

      (iii) Children who are the subject of a dependency petition or are adjudicated dependent and who are in the custody of the department and ordered by the court pursuant to section 8-845 to reside in an independent living program pursuant to section 8-521.

   (c) Providing services for children placed in adoption.

10. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

11. Make contracts and incur obligations within the general scope of the department's activities and operations subject to the availability of funds.

12. Coordinate with, contract with or assist other departments, agencies and institutions of this state and local and federal governments in the furtherance of the department's purposes, objectives and programs.

13. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.
14. Collect monies owed to the department.

15. Act as an agent of the federal government in furtherance of any functions of the department.

16. Carry on research and compile statistics relating to the child welfare program throughout this state, including all phases of dependency.

17. Cooperate with the superior court in all matters related to this title and title 13.

18. Provide the cost of care and transitional independent living services for a person under twenty-one years of age pursuant to section 8-521.01.

19. Ensure that all criminal conduct allegations and reports of imminent risk of harm are investigated.


21. Strengthen relationships with tribal child protection agencies or programs.

B. The director may:

1. Take administrative action to improve the efficiency of the department.

2. Contract with a private entity to provide any functions or services pursuant to this title.

3. Apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this title.

4. Reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business. Volunteers reimbursed for expenses are not eligible for workers' compensation under title 23, chapter 6.

C. The department shall administer individual and family services, including sections on services to children and youth and other related functions in furtherance of social service programs under the social security act, as amended, title IV, parts B and E, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services and other related federal acts and titles.

D. If the department has responsibility for the care, custody or control of a child or is paying the cost of care for a child, the department may serve as representative payee to receive and administer social security and veterans administration benefits and other benefits payable to the child. Notwithstanding any law to the contrary, the department:

1. Shall deposit, pursuant to sections 35-146 and 35-147, any monies it receives to be retained separate and apart from the state general fund on the books of the department of administration.

2. May use these monies to defray the cost of care and services expended by the department for the benefit, welfare and best interests of the child and invest any of the monies that the director determines are not necessary for immediate use.

3. Shall maintain separate records to account for the receipt, investment and disposition of monies received for each child.

4. On termination of the department's responsibility for the child, shall release any monies remaining to the child's credit pursuant to the requirements of the funding source or, in the absence of any requirements, shall release the remaining monies to:
(a) The child, if the child is at least eighteen years of age or is emancipated.

(b) The person who is responsible for the child if the child is a minor and not emancipated.

E. Subsection D of this section does not apply to benefits that are payable to or for the benefit of a child receiving services under title 36.

F. Notwithstanding any other law, a state or local governmental agency or a private entity is not subject to civil liability for the disclosure of information that is made in good faith to the department pursuant to this section.

G. Notwithstanding section 41-192, the department may employ legal counsel to provide legal advice to the director. The attorney general shall represent the department in any administrative or judicial proceeding pursuant to title 41, chapter 1, article 5.

H. The total amount of state monies that may be spent in any fiscal year by the department for foster care as provided in subsection A, paragraph 9, subdivision (b) of this section may not exceed the amount appropriated or authorized by section 35-173 for that purpose. This section does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.
8-121. Confidentiality of information; exceptions

A. It is unlawful, except for purposes for which files and records or social records or parts thereof or information therefrom have been released pursuant to subsection C of this section or section 8-120, 8-129, 8-134 or 36-340, or except for purposes allowed by order of the court, for any person to disclose, receive or make use of, or authorize, knowingly allow, participate in or acquiesce in the use of, any information involved in any proceeding under this article directly or indirectly derived from the files, records, reports or other papers compiled pursuant to this article, or acquired in the course of the performance of official duties until one hundred years after the date of the order issued pursuant to section 8-116. After one hundred years has elapsed from the date of the order issued pursuant to section 8-116 the court shall transfer all files, records, reports and other documents in possession of the court relating to the adoption to the Arizona state library, archives and public records. The items transferred pursuant to this subsection shall be available for public inspection during business hours and may be made available in an alternative format.

B. This section does not prohibit persons employed by the court, the division or an agency from conducting the investigations or performing other duties pursuant to this article within the normal course of their employment.

C. This section does not prohibit persons employed by the court, the division, an attorney participating or assisting in a direct placement adoption pursuant to section 8-130 or an agency from providing partial or complete identifying information between a birth parent and adoptive parent when the parties mutually agree to share specific identifying information and make a written request to the court, the division or the agency.

D. A person may petition the court to obtain information relating to an adoption in the possession of the court, the division or any agency or attorney involved in the adoption. Nonidentifying information may be released by the court pursuant to section 8-129. The court shall not release identifying information unless the person requesting the information has established a compelling need for disclosure of the information or consent has been obtained pursuant to subsection E of this section or from the birth parent pursuant to section 8-106. If a compelling need for disclosure of information is established, the court may decide what information, if any, should be disclosed and to whom and under what conditions disclosure may be made.

E. An adoptee who is eighteen years of age or older or a birth parent may file at any time with the court and the agency, division or attorney who participated in the adoption a notarized statement granting consent, withholding consent or withdrawing a consent previously given for the release of confidential information. If an adoptee who is eighteen years of age or older and the birth mother or birth father have filed a notarized statement granting consent to the release of confidential information, the court may disclose information, except identifying information relating to a birth parent who did not grant written consent, to the adoptee or birth parent.

F. This section does not prohibit a person from notifying a birth parent of the death of a child that the birth parent has placed for adoption.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (Expedited Rulemaking)
Title 9, Chapter 28

GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - EXPEDITED RULEMAKING

MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 12, 2022

SUBJECT: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Title 9, Chapter 28


Summary:

This expedited rulemaking from the Arizona Health Care Cost Containment System (AHCCCS) seeks to amend six (6) rules in Title 9, Chapter 28, Article 3 related to Arizona Long-Term Care System Preadmission Screening (PAS). Specifically, AHCCCS seeks to remove the mandatory face-to-face PAS assessment language from R9-28-303(C) to clarify that not all future PAS assessments will be conducted in-person through a face-to-face assessment. AHCCCS began conducting all PAS assessments telephonically due to COVID-19 precautions. Through updated procedures resulting from the COVID-19 pandemic, AHCCCS has determined that telephonic assessments provide greater efficiencies and flexibility for applicants, members and AHCCCS staff, thus allowing financial savings and benefits for the State, applicants, members, and, ultimately, the public. AHCCCS indicates there is no federal face-to-face PAS assessment requirement; therefore, AHCCCS proposes, as part of this rulemaking, to remove the requirement that all such assessments occur face-to-face.

Additionally, AHCCCS proposes that the PAS instrument currently used for assessment of children with developmental disabilities who are age 6 through 11 years old be used for
children with physical disabilities who are age 6 through 11 years old. AHCCCS believes that using the same PAS instrument for children in both populations for this age range provides a more accurate assessment. AHCCCS indicates the mandatory physician consultant review process will remain the same.

Finally, AHCCCS proposes to remove R9-28-303(B)(3) because AHCCCS conducts initial assessments of applicants in the same manner regardless of setting. Therefore, specific assessment procedures for hospital and acute care settings are no longer necessary.

1. **Do the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)?**

   AHCCCS states this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated. Furthermore, AHCCCS indicates this rulemaking reduces or consolidates steps, procedures or processes in the rules pursuant to A.R.S. § 41-1027(A)(5). Additionally, AHCCCS indicates this rulemaking implements, without material change, a course of action that is proposed in a Five-Year Review Report (5YRR) approved by the Council within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the Secretary of State. See A.R.S. § 41-1027(A)(7). This rulemaking was proposed in the 5YRR for these rules approved by the Council on March 1, 2022.

   Council staff believes the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A).

2. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   AHCCCS cites both general and specific statutory authority for these rules.

3. **Do the rules establish a new fee or contain a fee increase?**

   This rulemaking does not establish a new fee or contain a fee increase.

4. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

   AHCCCS indicates it did not receive public or stakeholder comments related to this rulemaking.
5. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

AHCCCS indicates there were no changes to the rules between the Notice of Proposed Expedited Rulemaking published in the Administrative Register and the Notice of Final Expedited Rulemaking now before the Council.

6. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates that the rules are not more stringent than corresponding federal law.

7. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. AHCCCS indicates that the rules do not require a permit, license, or agency authorization.

8. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

AHCCCS indicates it did not review or rely on any study in conducting this rulemaking.

9. **Conclusion**

AHCCCS seeks to amend six (6) rules in Title 9, Chapter 28, Article 3 related to Arizona Long-Term Care System PAS. Specifically, AHCCCS proposes to remove the requirement that PAS assessments occur face-to-face. AHCCCS also proposes that the PAS instrument currently used for assessment of children with developmental disabilities who are age 6 through 11 years old be used for children with physical disabilities who are age 6 through 11 years old. Finally, AHCCCS proposes to remove R9-28-303(B)(3) because AHCCCS conducts initial assessments of applicants in the same manner regardless of setting. Therefore, specific assessment procedures for hospital and acute care settings are no longer necessary.

Pursuant to A.R.S. § 41-1027(H), an expedited rulemaking becomes effective immediately on filing with the Secretary of State.

Council staff recommends approval of this rulemaking.
June 21, 2022

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007


Dear Ms. Sornsin:

1. The close of record date: 7/5/2022
2. Explanation of how the expedited rule meets the criteria in A.R.S. 41-1027(A):
Under A.R.S. 41-1027(A), this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated, (5) Reduces or consolidates steps, procedures or processes in the rules and (7) Implements, without material change, a course of action that is proposed in a five-year review report approved by the council pursuant to section 41-1056 within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the secretary of state.

In addition under A.R.S. 41-1027(A)(5), AHCCCS began conducting all PAS assessments telephonically due to COVID-19 precautions. Through updated procedures resulting from the COVID-19 pandemic, AHCCCS has determined that telephonic assessments provide greater efficiencies and flexibility for applicants, members and AHCCCS staff, thus allowing financial savings and benefits for the State, applicants, members, and, ultimately, the public. The additional changes found in the Five-Year Review Report are needed to keep the rules clear, concise and understandable for members of the public.
3. **Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:**

   The entirety of the rulemaking was approved by the Council in a five-year-review report on March 1, 2022.

4. **A list of items enclosed:**
   a. Notice of Final Expedited Rulemaking, including the preamble, table of contents, and text of each rule; and
   b. General and specific statutes authorizing the rules, including relevant statutory definitions.

Sincerely,


Kasey Rogg

Kasey Rogg
Assistant Director

Attachments
NOTICE OF FINAL EXPEDITED RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:
   R9-28-301 Amend
   R9-28-303 Amend
   R9-28-304 Amend
   R9-28-305 Amend
   R9-28-306 Amend
   R9-28-307 Amend

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):
   Authorizing Statute: A.R.S. § 36-2932
   Implementing Statute: A.R.S. § 36-2936

3. The effective date of the rule:
The rule is effective the day the Notice of Final Expedited Rulemaking is filed with the Office of the Secretary of State.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:
   Notice of Docket Opening: 28 A.A.R. 1234, June 3, 2022
   Notice of Proposed Expedited Rulemaking: 28 A.A.R. 1208, June 3, 2022

5. The agency’s contact person who can answer questions about the rulemaking:
   Name: Nicole Fries
   Address: AHCCCS
   Office of Administrative Legal Services
   801 E. Jefferson, Mail Drop 6200
   Phoenix, AZ 85034
   Telephone: (602) 417-4232
   Fax: (602) 253-9115
   E-mail: AHCCCSRules@azahcccs.gov
   Web site: www.azahcccs.gov
6. **An agency’s justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**

Under A.R.S. 41-1027(A), this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated, (5) Reduces or consolidates steps, procedures or processes in the rules and (7) Implements, without material change, a course of action that is proposed in a five-year review report approved by the council pursuant to section 41-1056 within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the secretary of state. The entirety of this rulemaking was approved by the Council in a five-year-review report on March 1, 2022.

In addition under A.R.S. 41-1027(A)(5), AHCCCS seeks to remove the mandatory face-to-face PAS assessment language of R9-28-303(C) to clarify that not all future PAS assessments will be conducted in-person through a face-to-face assessment. AHCCCS began conducting all PAS assessments telephonically due to COVID-19 precautions. Through updated procedures resulting from the COVID-19 pandemic, AHCCCS has determined that telephonic assessments provide greater efficiencies and flexibility for applicants, members and AHCCCS staff, thus allowing financial savings and benefits for the State, applicants, members, and, ultimately, the public. There is no federal face-to-face PAS assessment requirement; therefore, AHCCCS proposes, as part of this rulemaking, to remove the requirement that all such assessments occur face-to-face.

Additionally, AHCCCS proposes that the PAS instrument currently used for assessment of children with developmental disabilities who are age 6 through 11 years old be used for children with physical disabilities who are age 6 through 11 years old. AHCCCS believes that using the same PAS instrument for children in both populations for this age range provides a more accurate assessment. The mandatory physician consultant review process will remain the same.

Finally, AHCCCS proposes to remove section B because AHCCCS conducts initial assessments of applicants in the same manner regardless of setting. Therefore, specific assessment procedures for hospital and acute care settings are no longer necessary.

The additional changes found in the Five-Year Review Report are needed to keep the rules clear, concise and understandable for members of the public.

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

A study was not referenced or relied upon when revising these regulations.
8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable.

9. **A summary of the economic, small business, and consumer impact:**

Under A.R.S. § 41-1055(D)(2), the Administration is not required to provide an economic, small business, and consumer impact statement.

10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

There were no changes between the proposed rulemaking and the final rulemaking.

11. **An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:**

No public comments were made.

12. **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:**

There are no other matters prescribed by statutes applicable specifically to the Administration or this specific rulemaking.

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

      Not applicable.

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

      Not applicable.

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

      No such analysis was submitted.

13. **A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:**
Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:
Not applicable.

The full text of the rules follows:

TITLE 9. HEALTH SERVICES
CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION – ARIZONA LONG-TERM CARE SYSTEM
ARTICLE 3. PREADMISSION SCREENING (PAS)

Section
R9-28-301. Definitions
R9-28-303. Preadmission Screening (PAS) Process
R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and/or Physically Disabled (EPD)
R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)
R9-29-307. The ALTCS Transitional Program for a Member who is Elderly and/or Physically Disabled (EPD) or Developmentally Disabled (DD)
ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions
A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

“Applicant” is defined in A.A.C. R9-22-101.

“Assessor” means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

- Is employed by the Administration to conduct PAS assessments,
- Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours, and
- Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.

“Current” means belonging to the present time.

“Disruptive behavior” means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant’s or member’s normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

“Frequency” means the number of times a specific behavior occurs within a specified interval.

“Functional assessment” means an evaluation of information about an applicant’s or member’s ability to perform activities related to:

- Developmental milestones,
- Activities of daily living,
- Communication, and
- Behavior.

“Immediate risk of institutionalization” means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration’s Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

“Intervention” means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

“Medical assessment” means an evaluation of an applicant’s or member’s medical condition and the applicant’s or member’s need for medical services.

“Medical or nursing services and treatments” or “services and treatments” means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.
“Physician consultant” means a physician who contracts with the Administration.

“Social worker” means an individual with two years of case management-related experience or a Baccalaureate or master’s degree in:

- Social work,
- Rehabilitation,
- Counseling,
- Education,
- Sociology,
- Psychology, or
- Other closely related field.

“Special diet” means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

“Toileting” means the process involved in an applicant’s or member’s managing of the elimination of urine and feces in an appropriate place.

“Vision” means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is EPD:

“Aggression” means physically attacking another, including:

- Throwing an object,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair,
- Scratching, and
- Physically threatening behavior.

“Bathing” means the process of washing, rinsing, and drying all parts of the body, including an applicant’s or member’s ability to transfer to a tub or shower and to obtain bath water and equipment.

“Continence” means the applicant’s or member’s ability to control the discharge of body waste from bladder and bowel.

“Dressing” means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant’s or member’s ability to put on artificial limbs, braces, and other appliances that are needed daily.

“Eating” means the process of putting food and fluids by any means into the digestive system.

“Emotional and cognitive functioning” means an applicant’s or member’s orientation and mental state, as evidenced by aggressive, self-injurious, wandering, disruptive, and resistive behaviors.
“EPD” means an applicant or member who is elderly and physically disabled.

“Grooming” means an applicant’s or member’s process of tending to appearance. Grooming includes: combing or brushing hair; washing face and hands; shaving; oral hygiene (including denture care); and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, nail care, and applying cosmetics.

“Mobility” means the extent of an applicant’s or member’s purposeful movement within a residential environment.

“Orientation” means an applicant’s or member’s awareness of self in relation to person, place, and time.

“Physically disabled” means an applicant or member who is determined to be physically impaired by the Administration through the PAS assessment as allowed under the Administration’s Section 1115 Waiver with CMS.

“Resistiveness” means inappropriately obstinate and uncooperative behaviors, including passive or active obstinate behaviors, or refusing to participate in self-care or to take necessary medications. Resistiveness does not include difficulties with auditory processing or reasonable expressions of self-advocacy.

“Self-injurious behavior” means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

“Sensory” means of or relating to the senses.

“Transferring” means an applicant’s or member’s ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

“Wandering” means an applicant’s or member’s moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

C. DD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is DD:

“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

“Aggression” means physically attacking another, including:

- Throwing objects,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair, and
- Scratching.

“Ambulation” means the ability to walk and includes quality of the walking and the degree of independence in walking.

“Bathing or showering” means an applicant’s or member’s ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.
“Clarity of communication” means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

“Community mobility” means the applicant’s or member’s ability to move about a neighborhood or community independently, by any mode of transportation.

“Crawling and standing” means an applicant’s or member’s ability to crawl and stand with or without support.

“DD” means developmentally disabled.

“Developmental milestone” means a measure of an applicant’s or member’s functional abilities, including:

- Fine motor skills,
- Gross motor skills,
- Communication,
- Socialization,
- Daily living skills, and
- Behaviors.

“Dressing” means the ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces nor does it reflect an applicant’s or member’s ability to match colors or choose clothing appropriate for the weather.

“Eating or drinking” means the process of putting food and fluid by any means into the digestive system.

“Expressive verbal communication” means an applicant’s or member’s ability to communicate thoughts with words or sounds.

“Food preparation” means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

“Hand use” means the applicant’s or member’s ability to use both hands, or one hand if an applicant or member has only one hand or has the use of only one hand.

“History” means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

“Personal hygiene” means the process of tending to one’s appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

“Rolling and sitting” means an applicant’s or member’s ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

“Running or wandering away” means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

“Self-injurious behavior” means an applicant’s or member’s repeated behavior that causes injury to the applicant or member.
“Verbal or physical threatening” means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.
“Wheelchair mobility” means an applicant’s or member’s mobility using a wheelchair and does not include the ability to transfer to and from the wheelchair.

R9-28-303. Preadmission Screening (PAS) Process

A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization:

1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD, except as specified in subsection (A)(2) for an applicant or member who is physically disabled and who is less than 6 years old. After assessing a child who is physically disabled and age 6 years to less than 12 years, the assessor shall refer the child for physician consultant review under subsections (G) through (J).

2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 to assess an applicant or member who is physically disabled and less than 6 years old. After assessing the child, the assessor shall refer the child for physician consultant review under subsections (G) through (J).

3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is DD and residing in a NF. After assessing a child who is DD and less than 6 months of age, the assessor shall refer the child for physician consultant review under subsections (G) through (J).

4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or a member who is DD and residing in a NF.

5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act.

B. For an initial assessment of an applicant who is in a hospital or other acute care setting:

1. A registered nurse assessor shall complete the PAS assessment; or

2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and

3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

C. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (F). The assessor shall make reasonable efforts to obtain the applicant’s or member’s available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:

1. Applicant or member,
2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant’s or member’s functional or medical condition.

D. Using the information described in subsection (C), an assessor shall complete the PAS assessment based on the assessor’s education, experience, professional judgment, and training.

E. After the assessor completes the PAS assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections (G) through (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.

F. Upon request from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an ICF-MR any time during the time period covered by the application would have been eligible to receive ALTCS benefits for those months.

G. In the following circumstances, the Administration shall request that a physician consultant review the PAS assessment, the available medical records, and use professional judgment to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with other medical conditions, places an applicant or member at immediate risk of institutionalization:

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant’s or member’s unique functional abilities or medical condition may place the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder;
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 who scores at or above the threshold specified in R9-28-304, but may not meet the requirements of A.R.S. § 36-2936. When an applicant or member who is seriously mentally ill scores at or above the threshold, the physician consultant shall exercise professional judgment to determine whether the applicant or member meets the requirements of A.R.S. § 36-2936.
6. An applicant is an AHCCCS acute care member and scores at or above the threshold specified in R9-28-304 but the Administration has reasonable cause to believe that the applicant’s condition is convalescent and requires less than 90 days of institutional care;

7. An applicant or member is a child who is physically disabled and is at least 6 but less than 12 years of age;

8. An applicant or member is a child who is physically disabled and is under 6 years of age; and

9. An applicant is under 6 months of age.

H. The physician consultant shall consider the following:
   1. Activities of daily living dependence;
   2. Delay in development;
   3. Continence;
   4. Orientation;
   5. Behavior;
   6. Any medical condition, including stability and prognosis of the condition;
   7. Any medical nursing treatment provided to the applicant or member including skilled monitoring, medication, and therapeutic regimens;
   8. The degree to which the applicant or member must be supervised;
   9. The skill and training required of the applicant or member’s caregiver; and
   10. Any other factor of significance to the individual case.

I. If the physician consultant is unable to make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant’s or member’s needs, including a primary care physician or other caregiver, to make the determination.

J. The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

A. The PAS instrument for an applicant or member who is EPD includes the following categories:
   1. Intake information category. The assessor solicits intake information category information on an applicant’s or member’s demographic background. The components of the intake information category are not included in the calculated PAS score.
   2. Functional assessment category. The assessor solicits functional assessment category information on an applicant’s or member’s:
      a. Need for assistance with activities of daily living, including:
         i. Bathing,
         ii. Dressing,
iii. Grooming,
iv. Eating,
v. Mobility,
vi. Transferring, and
vii. Toileting in the residential environment or other routine setting;
b. Communication and sensory skills, including hearing, expressive communication, and vision; and
c. Continence, including bowel and bladder functioning.

3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant’s or member’s:
   a. Orientation to person, place, and time. In soliciting this information, the assessor shall also take into account the caregiver’s judgment; and
   b. Behavior, including:
      i. Wandering
      ii. Self-injurious behavior,
      iii. Aggression,
      iv. Resistiveness, and
      v. Disruptive behavior.

4. Medical assessment category. The assessor solicits medical assessment category information on an applicant’s or member’s:
   a. Medical conditions that have an impact on the applicant’s or member’s functional ability in relation to activities of daily living, continence, and vision;
   b. Medical condition that requires medical or nursing service and treatment;
   c. Medication, treatment, and allergies;
   d. Specific services and treatments that the applicant or member is currently receiving; and
   e. Physical measurements, hospitalization history, and ventilator dependency.

B. The assessor shall use the PAS instrument to assess an applicant or member who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor’s PAS assessment to calculate three scores: a functional score, a medical score, and a total score.

1. Functional score:
   a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
   b. In the functional assessment matrix, all items in the following categories are scored according to subsection (C):
      i. Activities of daily living,
ii. Continence, 
iii. Sensory, 
iv. Orientation, and 
v. Behavior. 
c. The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is 166.

2. Medical score. 
a. In the medical assessment matrix, all items in the following categories are scored according to:
   i. Medical conditions as specified in subsection (C), and
   ii. Medical or nursing services and treatments in subsection (C).
b. The Administration calculates the medical score based on the applicant’s or member’s:
   i. Diagnosis of Alzheimer’s, or dementia, or organic brain syndrome (OBS); 
   ii. Diagnosis of paralysis; and
   iii. Current use of oxygen. 
c. The maximum medical score attainable by an applicant or member is 31.5.

3. Total score. 
a. The sum of an applicant’s or member’s functional and medical scores equals the total score. 
b. The total score is compared to the established threshold score as calculated under this Section. The threshold score is 60. 
c. As defined in R9-28-303, an applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.

C. The following matrices represent the number of points available and the respective weight for each scored item.

1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.

2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
   a. Does not have the scored medical condition, 
   b. Does not need the scored medical or nursing services, or 
   c. Does not receive the scored medical or nursing services.

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<th>Range of Possible Weighted Score Per Item (P)x(W)</th>
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<td>0-6</td>
</tr>
<tr>
<td>Orientation Section</td>
<td></td>
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</tr>
<tr>
<td>Place</td>
<td>0-4</td>
<td>.5</td>
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</tr>
<tr>
<td>Time</td>
<td>0-4</td>
<td>.5</td>
<td>0-2</td>
</tr>
<tr>
<td>Emotional or Cognitive Behavior Section</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Aggression-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Aggression-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Self-injurious-Frequency</td>
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<td>1.5</td>
<td>0-4.5</td>
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<td>Wandering-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Wandering-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Resistiveness-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Resistiveness-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Disruptive-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Disruptive-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
</tbody>
</table>

**MEDICAL ASSESSMENT**

<table>
<thead>
<tr>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P)x(W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Conditions Section</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td>0-1</td>
<td>6.5</td>
</tr>
<tr>
<td>Alzheimer’s, or OBS, or Dementia</td>
<td>0-1</td>
<td>20</td>
</tr>
<tr>
<td>Services and Treatments Section</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td>0-1</td>
<td>5</td>
</tr>
</tbody>
</table>

Page 14 of 21
R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:

1. Twelve years of age and older,
2. Six through 11 years of age, and
3. Birth through 5 years of age.

B. The PAS instruments for an applicant or member who is DD include three major categories:

1. Intake information category. The assessor solicits intake information category information on an applicant’s or member’s demographic background. The components of this category are not included in the calculated PAS score.

2. Functional assessment category. The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (e):

   a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant’s or member’s:

      i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;

      ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and

      iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.

   b. For an applicant or member 6 through 11 years of age, the assessor solicits the functional assessment category information on an applicant’s or member’s:

      i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;

      ii. Communication, including expressive verbal communication and clarity of communication; and

      iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.

   c. For an applicant or member 6 months through 5 years of age, the assessor solicits the functional assessment category information on an applicant’s or member’s performance
with respect to a series of developmental milestones that measure an applicant’s or member’s degree of functional growth.

d. For an applicant or member less than 6 months of age, the assessor shall not complete a functional assessment. The assessor shall include a description of the applicant’s or member’s development in the PAS instrument narrative summary.

3. Medical assessment category. The assessor solicits medical assessment category information on an applicant’s or member’s:
   a. Medical condition;
   b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
   c. Current medication;
   d. Medical stability;
   e. Sensory functioning;
   f. Physical measurements; and
   g. Current living arrangement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.

C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor’s PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned a number of points which is multiplied by a weighted numerical value, resulting in a weighted score for each response.
   b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
      i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
      ii. For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
      iii. For an applicant or member 6 months of age through 5 years of age, items in the developmental milestones section are scored based on the age of the applicant.
   c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:
2. Medical score.
   a. Subsections (C)(2)(a)(i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
      i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and 6 years of age through 11 years of age.
      ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member 6 months of age through 5 years of age.
      iii. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
      iv. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
   b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>RANGE OF POINTS PER ITEM</th>
<th>MAXIMUM MEDICAL SCORE ATTAINABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>0 - 20.6</td>
<td>21.4</td>
</tr>
<tr>
<td>6-11</td>
<td>0 - 2.5</td>
<td>5</td>
</tr>
<tr>
<td>0-5</td>
<td>0 - 10</td>
<td>60</td>
</tr>
</tbody>
</table>

c. No minimum medical score is required.

3. Total score.
   a. The sum of an applicant’s or member’s functional and medical scores equals the total score.
b. The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.

D. The following matrices represent the number of points available and the weight for each scored item.

1. Functional assessment points. An applicant or member age group 0 to 5: The value is received for each negative response. An applicant or member age groups 6 to 11 and 12+; the lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.

2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
   a. Does not have a medical condition specified in the following matrices,
   b. Does not need medical or nursing service as specified in the following matrices, or
   c. Does not receive any medical or nursing service as specified in the following matrices.

<table>
<thead>
<tr>
<th>AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living Skills Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Use, Food Preparation</td>
<td>0-3</td>
<td>3.5</td>
<td>0-10.5</td>
</tr>
<tr>
<td>Ambulation, Toileting, Eating, Dressing,</td>
<td>0-4</td>
<td>2.8</td>
<td>0-11.2</td>
</tr>
<tr>
<td>Personal Hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicative Skills and Cognitive Abilities Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associating Time, Remembering Instructions</td>
<td>0-3</td>
<td>0.5</td>
<td>0-1.5</td>
</tr>
<tr>
<td>Behavior Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression, Threatening, Self Injurious</td>
<td>0-4</td>
<td>2.8</td>
<td>0-11.2</td>
</tr>
<tr>
<td>Resistive</td>
<td>0-3</td>
<td>3.5</td>
<td>0-10.5</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Age Group 12 and Older Medical Assessment</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Condition Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>0-1</td>
<td>0.4</td>
<td>0-0.4</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0-1</td>
<td>0.4</td>
<td>0-0.4</td>
</tr>
<tr>
<td>Moderate, Severe or Profound Mental Retardation</td>
<td>0-1</td>
<td>0-20.6</td>
<td>0-20.6</td>
</tr>
<tr>
<td>AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT</td>
<td># of Points Available Per Item (P)</td>
<td>Weight (W)</td>
<td>Range of Possible Weighted Score Per Item (P) x (W)</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------</td>
<td>------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Medical Conditions Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy, Epilepsy</td>
<td>0-1</td>
<td>0.4</td>
<td>0-4</td>
</tr>
<tr>
<td>Moderate, Severe, Profound Mental Retardation 0</td>
<td>0-1</td>
<td>20.6</td>
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</table>

<table>
<thead>
<tr>
<th>AGE GROUP 6-11 FUNCTIONAL ASSESSMENT</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living Skills Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs, Wheelchair Mobility, Bladder Control</td>
<td>0-3</td>
<td>1.875</td>
<td>0-5.625</td>
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<tr>
<td>Ambulation, Dressing, Bathing, Toileting</td>
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<td>1.5</td>
<td>0-6</td>
</tr>
<tr>
<td>Crawling or Standing</td>
<td>0-5</td>
<td>1.25</td>
<td>0-6.25</td>
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<tr>
<td>Rolling or Sitting</td>
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<td>0-6.66</td>
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<td>Communication Section</td>
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<tr>
<td>Clarity</td>
<td>0-4</td>
<td>1.5</td>
<td>0-6</td>
</tr>
<tr>
<td>Expressive Communication</td>
<td>0-5</td>
<td>1.25</td>
<td>0-6.25</td>
</tr>
<tr>
<td>Behavior Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wandering</td>
<td>0-4</td>
<td>6</td>
<td>0-24</td>
</tr>
<tr>
<td>Disruptive</td>
<td>0-3</td>
<td>7.5</td>
<td>0-22.5</td>
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<table>
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<tr>
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<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
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<tbody>
<tr>
<td>Medical Condition Section</td>
<td></td>
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</tr>
<tr>
<td>Cerebral Palsy</td>
<td>0-1</td>
<td>0-2.5</td>
<td>0-2.5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0-1</td>
<td>0-2.5</td>
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<table>
<thead>
<tr>
<th>AGE GROUP 6 – 11 MEDICAL ASSESSMENT</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
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</thead>
<tbody>
<tr>
<td>Medical Conditions Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy, Epilepsy</td>
<td>0-1</td>
<td>2.50</td>
<td>0-2.5</td>
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<table>
<thead>
<tr>
<th>AGE GROUP 0 – 5 FUNCTIONAL ASSESSMENT</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Age Group</td>
<td>Weight</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
</tr>
<tr>
<td>6-9 Months</td>
<td>5.0</td>
</tr>
<tr>
<td>9-11 Months</td>
<td>4.1</td>
</tr>
<tr>
<td>12-17 Months</td>
<td>2.9</td>
</tr>
<tr>
<td>18-23 Months</td>
<td>2.125</td>
</tr>
<tr>
<td>24-29 Months</td>
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</tr>
<tr>
<td>30-35 Months</td>
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</tr>
<tr>
<td>36-47 Months</td>
<td>1.34</td>
</tr>
<tr>
<td>48-59 Months</td>
<td>1.14</td>
</tr>
<tr>
<td>60 Months+</td>
<td>1.03</td>
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**AGE GROUP 0 – 5 MEDICAL ASSESSMENT**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Weight</th>
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</thead>
<tbody>
<tr>
<td>Cerebral Palsy</td>
<td>5.0</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.0</td>
</tr>
<tr>
<td>Moderate, Severe, or Profound Mental Retardation (36 Months and older only)</td>
<td>15.0</td>
</tr>
<tr>
<td>Autism + M-CHAT (18 Months and older only) Fails at least six M-CHAT based questions</td>
<td>7.0</td>
</tr>
<tr>
<td>Autism + Behaviors (30-35 Months only) Exhibits at least 3 of 4 specific behaviors</td>
<td>5.0</td>
</tr>
<tr>
<td>Autism + Behaviors (36 Months and older only) Exhibits at least 6 of 8 specific behaviors</td>
<td>10.0</td>
</tr>
<tr>
<td>Drug Regulation + Administration (6 Months to 35 Months)</td>
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</tr>
<tr>
<td>Drug Regulation + Administration (36 Months and older)</td>
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</tr>
<tr>
<td>Non-Bowel/Bladder Ostomy Care (6 Months to 35 Months)</td>
<td>7.0</td>
</tr>
<tr>
<td>Non-Bowel/Bladder Ostomy Care (36 Months and older)</td>
<td>5.0</td>
</tr>
<tr>
<td>Tube Feeding (6 Months to 35 Months)</td>
<td>7.0</td>
</tr>
<tr>
<td>Tube Feeding (36 Months and older)</td>
<td>5.0</td>
</tr>
<tr>
<td>Physical Therapy or Occupational Therapy (6 Months to 35 Months)</td>
<td>1.0</td>
</tr>
<tr>
<td>Physical Therapy or Occupational Therapy (36 Months and older)</td>
<td>1.5</td>
</tr>
<tr>
<td>Acute Hospital Admission (One)</td>
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<tr>
<td>Acute Hospital Admissions (Two or more)</td>
<td>2.0</td>
</tr>
<tr>
<td>Direct Care Staff Trained (6 Months to 11 Months)</td>
<td>0.5</td>
</tr>
<tr>
<td>Direct Care Staff Trained (12 Months and older)</td>
<td>1.0</td>
</tr>
<tr>
<td>Special Diet</td>
<td>2.0</td>
</tr>
</tbody>
</table>

**R9-28-306. Reassessments**

A. An assessor shall reassess an ALTCS member to determine continued eligibility:

   1. In connection with a routine audit of the PAS assessment by AHCCCS;
2. In connection with a request by a provider, program contractor, case manager, or other party, if AHCCCS determines that continued eligibility is uncertain due to substantial evidence of a change in the member’s circumstances or error in the PAS assessment; or

3. Annually when part of a population group identified by the Director in a written report as having an increased likelihood of becoming ineligible.

B. An assessor shall determine continued eligibility for ALTCS using the same criteria used for the initial PAS assessment as prescribed in R9-28-303.

C. An assessor shall refer the reassessment to physician consultant review if the member is:
   1. Determined ineligible,
   2. In the ALTCS Transitional Program under R9-28-307 and resides in a NF or ICF-MRIID, or
   3. Seriously mentally ill and no longer has a non-psychiatric medical condition that impacts the member’s ability to function.

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly or Physically Disabled (EPD) or Developmentally Disabled (DD)

A. The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD but do meet all other ALTCS eligibility criteria. The Administration shall compare the member’s PAS assessment to a scoring methodology for eligibility in the ALTCS transitional program as defined in subsections (B) and (C).

B. The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the total PAS score is less than the threshold described in R9-28-305 but is at least 30, or the member is diagnosed with moderate, severe, or profound mental retardation.

C. The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but is at least 40.

D. For a member residing in a NF or ICF-MRIID, the program contractor or the Administration shall ensure that the member is moved to an approved home- and community-based setting within 90 continuous days from the enrollment date of the member’s eligibility for the ALTCS transitional program.

E. A member in the ALTCS transitional program shall continue to receive all medically necessary covered services as specified in Article 2.

F. A member in the ALTCS transitional program is eligible to receive up to 90 continuous days per NF or ICF-MRIDI admission when the member’s condition worsens to the extent that an admission is medically necessary.

G. For a member requiring medically necessary NF or ICF-MRIDI services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment under R9-28-306.
a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;

b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and

c. Covered hospice services do not include:
   i. Medical services provided that are not related to the terminal illness, or
   ii. Home delivered meals.

d. Medicare is the primary payor of hospice services for a member if applicable.

**Historical Note**

**ARTICLE 3. PREADMISSION SCREENING (PAS)**

**R9-28-301. Definitions**

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

"Applicant” is defined in A.A.C. R9-22-101.

"Assessor” means a social worker as defined in this subsection or a licensed registered nurse (RN) who:
   i. Is employed by the Administration to conduct PAS assessments,
   ii. Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours, and
   iii. Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.

"Current” means belonging to the present time.

"Disruptive behavior” means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant’s or member’s normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

"Frequency” means the number of times a specific behavior occurs within a specified interval.

"Functional assessment” means an evaluation of information about an applicant’s or member’s ability to perform activities related to:
   a. Developmental milestones,
   b. Activities of daily living,
   c. Communication, and
   d. Behavior.

"Immediate risk of institutionalization” means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration’s Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

"Intervention” means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

"Medical assessment” means an evaluation of an applicant’s or member’s medical condition and the applicant’s or member’s need for medical services.

"Medical or nursing services and treatments” or “services and treatments” means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.

"Physician consultant” means a physician who contracts with the Administration.

"Social worker” means an individual with two years of case management-related experience or a baccalaureate or master’s degree in:
   a. Social work,
   b. Rehabilitation,
   c. Counseling,
   d. Education,
   e. Sociology,
   f. Psychology, or
   g. Other closely related field.

"Special diet” means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

"Toileting” means the process involved in an applicant’s or member’s managing of the elimination of urine and feces in an appropriate place.

"Vision” means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is EPD:

"Aggression” means physically attacking another, including:
   a. Throwing an object,
   b. Punching,
   c. Biting,
   d. Pushing,
   e. Pinching,
   f. Pulling hair,
   g. Scratching, and
   h. Physically threatening behavior.

"Bathing” means the process of washing, rinsing, and drying all parts of the body, including an applicant’s or member’s ability to transfer to a tub or shower and to obtain bath water and equipment.

"Continence” means the applicant’s or member’s ability to control the discharge of body waste from bladder and bowel.

"Dressing” means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant’s or member’s ability to
C. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is DD:

“Acute” means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

“Aggression” means physically attacking another, including:

- Throwing objects,
- Punching,
- Biting,
- Pushing,
- Pinching,
- Pulling hair, and
- Scratching.

“Ambulation” means the ability to walk and includes quality of the walking and the degree of independence in walking.

“Bathing or showering” means an applicant’s or member’s ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

“Clarity of communication” means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

“Community mobility” means the applicant’s or member’s ability to move about a neighborhood or community independently, by any mode of transportation.

“Crawling and standing” means an applicant’s or member’s ability to crawl and stand with or without support.

“DD” means developmentally disabled.

“Developmental milestone” means a measure of an applicant’s or member’s functional abilities, including:

- Fine motor skills,
- Gross motor skills,
- Communication,
- Socialization,
- Daily living skills, and
- Behaviors.

“Dressing” means the ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces nor does it reflect an applicant’s or member’s ability to match colors or choose clothing appropriate for the weather.

“Eating” means the process of putting food and fluid by any means into the digestive system.

“Expressive verbal communication” means an applicant’s or member’s ability to communicate thoughts with words or sounds.

“Food preparation” means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

“Hand use” means the applicant’s or member’s ability to use both hands, or one hand if an applicant or member has only one hand or has the use of only one hand.

“History” means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

“Personal hygiene” means the process of tending to one’s appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

“Rolling and sitting” means an applicant’s or member’s ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

“Running or wandering away” means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

“Self-injurious behavior” means an applicant’s or member’s repeated behavior that causes injury to the applicant or member.

“Verbal or physical threatening” means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

“Wheelchair mobility” means an applicant’s or member’s mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (C) effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective Septem-
To qualify for services described in A.R.S. § 36-2939:


A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization under the PAS assessment as specified in this Article.

B. AHCCCS shall determine that the applicant is at immediate risk of institutionalization under the PAS assessment.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Office of the Secretary of State June 30, 1995 (Supp. 95-2). Section repealed by new Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4). Amended by final rulemaking at 17 A.A.R. 167, effective March 12, 2011 (Supp. 11-1).

R9-28-303. Preadmission Screening (PAS) Process

A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization:

1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except as specified in subsection (A)(2) for an applicant or member who is physically disabled and who is less than 6 years old. After assessing a child who is physically disabled and age 6 years to less than 12 years, the assessor shall refer the child for a face-to-face interview with the:  
   1. Applicant or member,
   2. Parent,
   3. Guardian,
   4. Caregiver, or
   5. Any person familiar with the applicant's or member's functional or medical condition.

2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 to assess an applicant or member who is physically disabled and less than 6 years old. After assessing the child, the assessor shall refer the child for a face-to-face interview with the:  
   1. Applicant or member,
   2. Parent,
   3. Guardian,
   4. Caregiver, or
   5. Any person familiar with the applicant's or member's functional or medical condition.

3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is DD and residing in a NF. After assessing a child who is DD and less than 6 months of age, the assessor shall refer the child for a face-to-face interview with the:  
   1. Applicant or member,
   2. Parent,
   3. Guardian,
   4. Caregiver, or
   5. Any person familiar with the applicant's or member's functional or medical condition.

4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or member who is DD and residing in a NF.

5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act.

B. For an initial assessment of an applicant who is in a hospital or other acute care setting:

1. A registered nurse assessor shall complete the PAS assessment;
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

C. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (F).

D. Using the information described in subsection (C), an assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:

1. Applicant or member,
2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

E. After the assessment completes the PAS assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by a physician consultant, review as provided in subsections (G) through (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.

F. Upon request from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an ICF-MR any time during the time period covered by the application would have been eligible to receive ALTCS benefits for those months.

G. In the following circumstances, the Administration shall request that a physician consultant review the PAS assessment, the available medical records, and use professional judgment to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with other medical conditions, places an applicant or member at immediate risk of institutionalization:

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition may place the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder;
The physician consultant shall consider the following:

J. The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

**Historical Note**


R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

A. The PAS instrument for an applicant or member who is EPD includes the following categories:

1. Intake information category. The assessor solicits intake information category information on an applicant’s or member’s demographic background. The components of the intake information category are not included in the calculated PAS score.

2. Functional assessment category. The assessor solicits functional assessment category information on an applicant’s or member’s:
   a. Need for assistance with activities of daily living, including:
      i. Bathing,
      ii. Dressing,
      iii. Grooming,
      iv. Eating,
      v. Mobility,
      vi. Transferring, and
   b. Communication and sensory skills, including hearing, expressive communication, and vision; and
   c. Continence, including bowel and bladder functioning.

3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant’s or member’s:
   a. Orientation to person, place, and time. In soliciting this information, the assessor shall also take into account the caregiver’s judgment; and
   b. Behavior, including:
      i. Wandering,
      ii. Self-injurious behavior,
      iii. Aggression,
      iv. Resistiveness, and
      v. Disruptive behavior.

4. Medical assessment category. The assessor solicits medical assessment category information on an applicant’s or member’s:
   a. Medical conditions that have an impact on the applicant’s or member’s functional ability in relation to activities of daily living, continence, and vision;
   b. Medical condition that requires medical or nursing service and treatment;
   c. Medication, treatment, and allergies;
   d. Specific services and treatments that the applicant or member is currently receiving; and
   e. Physical measurements, hospitalization history, and ventilator dependency.

B. The assessor shall use the PAS instrument to assess an applicant or member who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor’s PAS assessment to calculate three scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by
a weighted numerical value. The result is a weighted score for each response.

b. In the functional assessment matrix, all items in the following categories are scored according to subsection (C):
   i. Activities of daily living,
   ii. Continence,
   iii. Sensory,
   iv. Orientation, and
   v. Behavior.

c. The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is 166.

2. Medical score.
   a. In the medical assessment matrix, all items in the following categories are scored according to:
      i. Medical conditions as specified in subsection (C), and
      ii. Medical or nursing services and treatments in subsection (C).

b. The Administration calculates the medical score based on the applicant’s or member’s:
   i. Diagnosis of Alzheimer’s, dementia, or organic brain syndrome (OBS);
   ii. Diagnosis of paralysis; and
   iii. Current use of oxygen.

c. The maximum medical score attainable by an applicant or member is 31.5.

3. Total score.
   a. The sum of an applicant’s or member’s functional and medical scores equals the total score.
   b. The total score is compared to the established threshold score as calculated under this Section. The threshold score is 60.
   c. As defined in R9-28-303, an applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.

C. The following matrices represent the number of points available and the respective weight for each scored item.

1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.

2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
   a. Does not have the scored medical condition,
   b. Does not need the scored medical or nursing services, or
   c. Does not receive the scored medical or nursing services.

<table>
<thead>
<tr>
<th>FUNCTIONAL ASSESSMENT</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score per Item (P)x(W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Transfer</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Bathing</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Dressing</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Grooming</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Eating</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Toileting</td>
<td>0-3</td>
<td>5</td>
<td>0-15</td>
</tr>
<tr>
<td>Continence Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel</td>
<td>0-3</td>
<td>1</td>
<td>0-3</td>
</tr>
<tr>
<td>Bladder</td>
<td>0-3</td>
<td>1</td>
<td>0-3</td>
</tr>
<tr>
<td>Sensory Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>0-3</td>
<td>2</td>
<td>0-6</td>
</tr>
<tr>
<td>Orientation Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place</td>
<td>0-4</td>
<td>.5</td>
<td>0-2</td>
</tr>
<tr>
<td>Time</td>
<td>0-4</td>
<td>.5</td>
<td>0-2</td>
</tr>
<tr>
<td>Emotional or Cognitive Behavior Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Aggression-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Self-injurious-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Self-injurious-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Wandering-Frequency</td>
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<td>1.5</td>
<td>0-4.5</td>
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<tr>
<td>Wandering-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Resistiveness-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Resistiveness-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Disruptive-Frequency</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
</tr>
<tr>
<td>Disruptive-Intervention</td>
<td>0-3</td>
<td>1.5</td>
<td>0-4.5</td>
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</table>
### MEDICAL ASSESSMENT

<table>
<thead>
<tr>
<th>Medical Conditions Section</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P)x(W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paralysis</td>
<td>0-1</td>
<td>6.5</td>
<td>0 or 6.5</td>
</tr>
<tr>
<td>Alzheimer’s, or OBS, or Dementia</td>
<td>0-1</td>
<td>20</td>
<td>0 or 20</td>
</tr>
</tbody>
</table>

### Services and Treatments Section

| Oxygen                     | 0-1                               | 5          | 0 or 5                                        |

#### Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed as an emergency rule with the Secretary of State’s Office June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-304 renumbered to R9-28-305; new Section R9-28-304 renumbered from R9-28-303 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

### R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

#### A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:
1. Twelve years of age and older,
2. Six through 11 years of age, and
3. Birth through 5 years of age.

#### B. The PAS instruments for an applicant or member who is DD include three major categories:

1. **Intake information category.** The assessor solicits intake information category information on an applicant’s or member’s demographic background. The components of this category are not included in the calculated PAS score.
   - a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant’s or member’s:
     - i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
     - ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
     - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.

2. **Functional assessment category.** The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (e):
   - a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant’s or member’s:
     - i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
     - ii. Communication, including expressive verbal communication and clarity of communication; and
     - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
   - b. For an applicant or member 6 through 11 years of age, the assessor solicits the functional assessment category information on an applicant’s or member’s:
     - i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
     - ii. Communication, including expressive verbal communication and clarity of communication; and
     - iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
   - c. For an applicant or member 6 months through 5 years of age, the assessor solicits the functional assessment category information on an applicant’s or member’s performance with respect to a series of developmental milestones that measure an applicant’s or member’s degree of functional growth.
   - d. For an applicant or member less than 6 months of age, the assessor shall not complete a functional assessment. The assessor shall include a description of the applicant’s or member’s development in the PAS instrument narrative summary.

3. **Medical assessment category.** The assessor solicits medical assessment category information on an applicant’s or member’s:
   - a. Medical condition;
   - b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
   - c. Current medication;
   - d. Medical stability;
   - e. Sensory functioning;
   - f. Physical measurements; and
   - g. Current living arrangement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.

#### C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor’s PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

1. **Functional score.**
   - a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned a number of points which is multiplied by a weighted
numerical value, resulting in a weighted score for each response.
b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
   i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
   ii. For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
   iii. For an applicant or member 6 months of age through 5 years of age, items in the developmental milestones section are scored based on the age of the applicant.

c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>RANGE FOR WEIGHTED SCORE PER ITEM</th>
<th>MAXIMUM FUNCTIONAL SCORE ATTAINABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>0 - 11.2</td>
<td>124.1</td>
</tr>
<tr>
<td>6-11</td>
<td>0 - 24</td>
<td>112.5</td>
</tr>
<tr>
<td>0-5</td>
<td>0 - 5.0</td>
<td>106.02</td>
</tr>
</tbody>
</table>

d. No minimum functional score is required.

2. Medical score.
a. Subsections (C)(2)(a)(i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
   i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and 6 years of age through 11 years of age.
   ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member 6 months of age through 5 years of age.
   iii. The assessor shall complete only the medical assessment section of the PAS for an applicant or member 6 months of age or younger. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.

   iv. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.

b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th>RANGE OF POINTS PER ITEM</th>
<th>MAXIMUM MEDICAL SCORE ATTAINABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>0 - 20.6</td>
<td>21.4</td>
</tr>
<tr>
<td>6-11</td>
<td>0 - 2.5</td>
<td>5</td>
</tr>
<tr>
<td>0-5</td>
<td>0 - 10</td>
<td>60</td>
</tr>
</tbody>
</table>

c. No minimum medical score is required.

3. Total score.
a. The sum of an applicant’s or member’s functional and medical scores equals the total score.
b. The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.

D. The following matrices represent the number of points available and the weight for each scored item.

1. Functional assessment points. An applicant or member age group 0 to 5: The value is received for each negative response. An applicant or member age groups 6 to 11 and 12+: the lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.

2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
   a. Does not have a medical condition specified in the following matrices,
   b. Does not need medical or nursing service as specified in the following matrices,
   c. Does not receive any medical or nursing service as specified in the following matrices.

<table>
<thead>
<tr>
<th>AGE GROUP</th>
<th># OF POINTS AVAILABLE PER ITEM (P)</th>
<th>WEIGHT (W)</th>
<th>RANGE OF POSSIBLE WEIGHTED SCORE PER ITEM (P) X (W)</th>
</tr>
</thead>
</table>
| Independent Living Skills Section
| Hand Use, Food Preparation          | 0-3        | 3.5        | 0-10.5                                             |
| Ambulation, Toileting, Eating, Dressing, Personal Hygiene | 0-4 | 2.8 | 0-11.2                                             |
| Communicative Skills and Cognitive Abilities Section
| Associating Time, Remembering Instructions | 0-3 | 0.5 | 0 - 1.5                                            |
| Behavior Section
| Aggression, Threatening, Self Injurious | 0-4 | 2.8 | 0-11.2                                             |
| Resistive                             | 0-3        | 3.5        | 0-10.5                                             |
### AGE GROUP 12 AND OLDER

#### MEDICAL ASSESSMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Palsy, Epilepsy</td>
<td>0-1</td>
<td>0.4</td>
<td>0-.4</td>
</tr>
<tr>
<td>Moderate, Severe, Profound Retardation</td>
<td>0-1</td>
<td>20.6</td>
<td>0-20.6</td>
</tr>
</tbody>
</table>

### AGE GROUP 6-11

#### FUNCTIONAL ASSESSMENT

<table>
<thead>
<tr>
<th>Section</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living Skills Section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs, Wheelchair Mobility, Bladder Control</td>
<td>0-3</td>
<td>1.875</td>
<td>0-5.625</td>
</tr>
<tr>
<td>Ambulation, Dressing, Bathing, Toileting</td>
<td>0-4</td>
<td>1.5</td>
<td>0-6</td>
</tr>
<tr>
<td>Crawling or Standing</td>
<td>0-5</td>
<td>1.25</td>
<td>0-6.25</td>
</tr>
<tr>
<td>Rolling or Sitting</td>
<td>0-8</td>
<td>0.833</td>
<td>0-6.66</td>
</tr>
</tbody>
</table>

#### Communication Section

| Clarity                   | 0-4 | 1.5 | 0-6                                           |
| Expressive Communication  | 0-5 | 1.25| 0-6.25                                        |

#### Behavior Section

| Wandering                | 0-4 | 6   | 0-24                                          |
| Disruptive               | 0-3 | 7.5 | 0-22.5                                        |

### AGE GROUP 6 - 11

#### MEDICAL ASSESSMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Points Available Per Item (P)</th>
<th>Weight (W)</th>
<th>Range of Possible Weighted Score Per Item (P) x (W)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Palsy, Epilepsy</td>
<td>0-1</td>
<td>2.50</td>
<td>0-2.5</td>
</tr>
</tbody>
</table>

### AGE GROUP 0 – 5

#### FUNCTIONAL ASSESSMENT

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 9 Months</td>
<td>5.0</td>
</tr>
<tr>
<td>9 - 11 Months</td>
<td>4.1</td>
</tr>
<tr>
<td>12 - 17 Months</td>
<td>2.9</td>
</tr>
<tr>
<td>18 - 23 Months</td>
<td>2.125</td>
</tr>
<tr>
<td>24 - 29 Months</td>
<td>1.75</td>
</tr>
<tr>
<td>30 - 35 Months</td>
<td>1.55</td>
</tr>
<tr>
<td>36 - 47 Months</td>
<td>1.34</td>
</tr>
<tr>
<td>48 - 59 Months</td>
<td>1.14</td>
</tr>
<tr>
<td>60 Months+</td>
<td>1.03</td>
</tr>
</tbody>
</table>

### AGE GROUP 0 - 5

#### MEDICAL ASSESSMENT

<table>
<thead>
<tr>
<th>Condition</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral Palsy</td>
<td>5.0</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.0</td>
</tr>
<tr>
<td>Moderate, Severe, or Profound Mental Retardation (36 Months and older only)</td>
<td>15.0</td>
</tr>
<tr>
<td>Autism + M-CHAT (18 Months and older only) Fails at least six M-CHAT based questions</td>
<td>7.0</td>
</tr>
<tr>
<td>Autism + Behaviors (30-35 Months only) Exhibits at least 3 of 4 specific behaviors</td>
<td>5.0</td>
</tr>
<tr>
<td>Autism + Behaviors (36 Months and older only) Exhibits at least 6 of 8 specific behaviors</td>
<td>10.0</td>
</tr>
<tr>
<td>Drug Regulation + Administration (6 Months to 35 Months)</td>
<td>1.0</td>
</tr>
<tr>
<td>Drug Regulation + Administration (36 Months and older)</td>
<td>1.5</td>
</tr>
<tr>
<td>Non-Bowel/Bladder Ostomy Care (6 Months to 35 Months)</td>
<td>7.0</td>
</tr>
<tr>
<td>Non-Bowel/Bladder Ostomy Care (36 Months and older)</td>
<td>5.0</td>
</tr>
<tr>
<td>Tube Feeding (6 Months to 35 Months)</td>
<td>7.0</td>
</tr>
<tr>
<td>Tube Feeding (36 Months and older)</td>
<td>5.0</td>
</tr>
<tr>
<td>Physical Therapy or Occupational Therapy (6 Months to 35 Months)</td>
<td>1.0</td>
</tr>
</tbody>
</table>
R9-28-306. Reassessments
A. An assessor shall reassess an ALTCS member to determine continued eligibility:

1. In connection with a routine audit of the PAS assessment by AHCCCS;
2. In connection with a request by a provider, program contractor, case manager, or other party, if AHCCCS determines that continued eligibility is uncertain due to substantial evidence of a change in the member’s circumstances or error in the PAS assessment;
3. Annually when part of a population group identified by the Director in a written report as having an increased likelihood of becoming ineligible.

B. An assessor shall determine continued eligibility for ALTCS using the same criteria used for the initial PAS assessment as prescribed in R9-28-303.

C. An assessor shall refer the reassessment to physician consultant review if the member is:

1. Determined ineligible;
2. In the ALTCS Transitional Program under R9-28-307 and resides in a NF or ICF-MR, or
3. Seriously mentally ill and no longer has a non-psychiatric medical condition that impacts the member’s ability to function.

Historical Note

R9-28-307. The ALTCS Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)
A. The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD but do meet all other ALTCS eligibility criteria. The Administration shall compare the member’s PAS assessment to a scoring methodology for eligibility in the ALTCS transitional program as defined in subsections (B) and (C).

B. The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the member is diagnosed with moderate, severe, or profound mental retardation.

C. The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but is at least 40.

D. For a member residing in a NF or ICF-MR, the program contractor or the Administration shall ensure that the member is moved to an approved home- and community-based setting within 90 continuous days from the enrollment date of the member’s eligibility for the ALTCS transitional program.

E. A member in the ALTCS transitional program shall continue to receive all medically necessary covered services as specified in Article 2.

F. A member in the ALTCS transitional program is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member’s condition worsens to the extent that an admission is medically necessary.

G. For a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment under R9-28-306.

Historical Note
New Section renumbered from R9-28-306 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 12 A.A.R. 4007, effective October 5, 2006 (Supp. 06-4).

ARTICLE 4. ELIGIBILITY AND ENROLLMENT
R9-28-401. Eligibility and Enrollment-Related Definitions
Definitions. For purposes of this Article, the following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

“ALTCS acute care services” means services under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 and who:

- Lives in an acute care living arrangement described in R9-28-406; or
- Is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration, or
- Has refused institutionalized or HCBS services.

“Community spouse” means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by the state of Arizona, and who does not live in a medical institution.
A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.
2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.
3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' requests for proposals for providers and provider subcontracts.
4. Providing technical assistance to the program contractors.
5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.
6. Conducting quality control on eligibility determinations and preadmission screenings.
7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.
8. Establishing an enrollment system.
9. Establishing a member case management tracking system.
10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.
11. Coordinating benefits as provided in section 36-2946.
12. Establishing standards for the coordination of services.
13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.
14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.
15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.
16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and posteligibility treatment of income pursuant to subsection L of this section.
17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.
18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall contract periodically as deemed necessary and as required by federal law for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for...
a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules to specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules that provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

J. The director may apply for federal monies available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state monies appropriated for the administration of the system may be used as matching monies to secure federal monies pursuant to this subsection.

K. The director shall adopt rules that establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources that determine the portion of a member's income that shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.
2. The maintenance needs of a spouse or family at home in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.

3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract that does not conform to federal requirements or that may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.
2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.
A. The director shall adopt rules establishing a uniform statewide preadmission screening program to determine if a person who has met the eligibility criteria prescribed in section 36-2934 is eligible for institutional services pursuant to this article. To be eligible for institutional services or home and community based services as defined in section 36-2931, a person shall have a nonpsychiatric medical condition or have a developmental disability as defined in section 36-551 that, by itself or in combination with other medical conditions, necessitates the level of care that is provided in a nursing facility or intermediate care facility. These rules shall establish a uniform preadmission screening instrument that assesses the functional, medical, nursing, social and developmental needs of the applicant.

B. A person is not eligible to receive home and community based services unless that person has been determined to need institutional services as determined by the preadmission screening instrument pursuant to subsection C of this section. The administration shall establish guidelines for the periodic reassessment of each member.

C. Preadmission screening conducted pursuant to subsection B of this section shall be conducted by a registered nurse licensed pursuant to title 32, chapter 15 or a social worker. The nurse or social worker shall have a physician licensed pursuant to title 32, chapter 13 or 17 available for consultation and may use the applicant's attending physician's physical assessment form, if appropriate, in assessing needs for long-term care services under this article. A physician who receives a referral from the nurse or social worker may use the physician's medical judgment to determine the medical eligibility of an applicant for the system or the continued medical eligibility of a member or eligible person. In the medical referral, the physician shall use the established combined thresholds for functional ability and medical condition as a guide to determine the risk of institutionalization.

D. If a person who is eligible for services pursuant to this article, who is enrolled with a program contractor pursuant to this article and who is enrolled with a program contractor pursuant to section 36-2940 fails the preadmission screening for institutional services pursuant to subsection A of this section at the time of a reassessment, the administration may administer a second preadmission screening designed to measure the functioning level of the person based on rules adopted by the director. If the person meets the established thresholds of the functional preadmission screening, the person is eligible for home and community based services pursuant to section 36-2939, subsection A, paragraphs 2, 3 and 4, subsection B, paragraph 2 and subsection C. If a person who is determined eligible pursuant to this subsection is institutionalized pursuant to section 36-2939, including residence in an intermediate care facility, institution for mental disease, inpatient psychiatric facility or nursing facility, the person has a maximum of ninety days to vacate the institutional setting and relocate to a home and community based setting approved pursuant to section 36-2939.

E. If the person is determined not to need services pursuant to this section, the administration shall provide the person with information on other available community services.

F. The administration or its designee shall complete the preadmission screening under subsection A of this section within eight days, excluding Saturdays and holidays, and excluding the time period allowed to determine eligibility pursuant to section 36-2934.

G. If a provider who contracts with the administration pursuant to section 36-2904, subsection A is dissatisfied with any action or decision of the administration regarding the eligibility of a person for the system as prescribed in this article, that provider may file a grievance in accordance with the provider grievance procedure prescribed in section 36-2932, subsection I, paragraph 1. If the director determines pursuant to the grievance process that the person should have been determined eligible pursuant to section 36-2933, the director may reimburse the provider for the net cost of services provided pursuant to this article after the cumulative time periods allowed pursuant to section 36-2934 and this section.

H. In addition to those persons seeking services pursuant to this article, the preadmission screening conducted pursuant to this section shall be made available to all other persons applying for admission to a nursing care institution. The cost of preadmission screenings conducted by the administration pursuant to this subsection shall be borne by the state. The administration shall provide nursing care institutions and the general public on request with detailed information about the preadmission screening program and booklets that describe in clear and simple language the availability of services and benefits from the system. The booklet shall:

1. Explain the availability of preadmission screening that will assess the functional, medical, nursing and social needs of the patient and make recommendations on services that meet the patient's needs as identified by the preadmission screening assessment.
2. Describe the availability of public and private services appropriate to meet the patient's needs in institutions and alternatives to institutions.

3. Explain financial eligibility standards for the Arizona long-term care system and its effect on separate and community property.

I. In addition to the preadmission screening program established in this section, the administration shall implement the preadmission screening program as set forth in section 1919 of the social security act. For persons applying for admission to a title XIX certified nursing care institution, an initial level I preadmission screening shall be conducted by the administration on all nursing care institution applicants who are applying for eligibility pursuant to section 36-2933 and by the nursing care institution on all other nursing care institution applicants. The administration shall develop a uniform identification screening instrument, which shall be used by the nursing care institution and the administration in conducting the initial level I screens. If the identification screen indicates the applicant may be mentally ill, the applicant shall be referred to the department of health services, which shall conduct the level II preadmission screening review using a level II screening instrument developed by the department of health services. If the identification screen indicates the applicant may have an intellectual disability, the applicant shall be referred to the department, which shall conduct the level II preadmission screening review using a level II screening instrument developed by the department.

J. Within ten working days a nursing care institution shall notify the department of health services for a person who is mentally ill or the department of economic security for a person with developmental disabilities and the department of child safety if the person is a minor dependent of this state about any significant change that occurs in the physical or mental condition of a member who is residing in the nursing care institution. The department of health services or the department of economic security shall conduct a subsequent level II screening review of the member within the time frame required by the administration after the notification by the nursing care institution.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (Expedited Rulemaking)
Title 9, Chapter 31

MEETING DATE:  September 7, 2022

TO:  Members of the Governor’s Regulatory Review Council (Council)

FROM:  Council Staff

DATE:  August 12, 2022

SUBJECT:  ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Title 9, Chapter 31


Summary:

This expedited rulemaking from the Arizona Health Care Cost Containment System (AHCCCS) seeks to amend seven (7) rules in Title 9, Chapter 31, Articles 1, 3, 4, and 14 related to the Children’s Health Insurance Program. Specifically, AHCCCS seeks to remove outdated eligibility categories within R9-31-401 and R9-31-1408(D), in addition to updating the rules to reflect current timelines for both the period of ineligibility and the required timeline to provide verification of need. AHCCCS indicates these and other technical and conforming changes are necessary to help members and potential members understand AHCCCS KidsCare categories and processes, to decrease the regulatory burden on the public, and to keep the rules clear, concise, and understandable for members of the public.

1.  Do the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A)?

AHCCCS states this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated and implements, without material
change, a course of action that is proposed in a Five-Year Review Report (5YRR) approved by the Council within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the Secretary of State. See A.R.S. § 41-1027(A)(7). This rulemaking was proposed in the 5YRR for these rules approved by the Council on March 1, 2022.

Council staff believes the rules satisfy the criteria for expedited rulemaking pursuant to A.R.S. § 41-1027(A).

2. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

AHCCCS cites both general and specific statutory authority for these rules.

3. **Do the rules establish a new fee or contain a fee increase?**

This rulemaking does not establish a new fee or contain a fee increase.

4. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

AHCCCS indicates it did not receive public or stakeholder comments related to this rulemaking.

5. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

AHCCCS indicates that it made two formatting changes to these rules between the Notice of Proposed Expedited Rulemaking published in the Administrative Register and the Notice of Final Expedited Rulemaking now before the Council. First, in R9-31-101, AHCCCS states the symbol for section was added to citations to the United States Code in order to correctly format the citation. Second, in R9-31-301, AHCCCS states the headings were re-lettered correctly.

Council staff does not believe these changes between the Notice of Proposed Expedited Rulemaking and the Notice of Final Expedited Rulemaking make the rules “substantially different” as described in A.R.S. § 41-1025.

6. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates that the rules are not more stringent than corresponding federal law.
7. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

   Not applicable. AHCCCS indicates that the rules do not require a permit, license, or agency authorization.

8. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   AHCCCS indicates it did not review or rely on any study in conducting this rulemaking.

9. **Conclusion**

   AHCCCS seeks to amend seven (7) rules in Title 9, Chapter 31, Articles 1, 3, 4, and 14 related to the Children’s Health Insurance Program. Specifically, AHCCCS seeks to remove outdated eligibility categories within R9-31-401 and R9-31-1408(D), in addition to updating the rules to reflect current timelines for both the period of ineligibility and the required timeline to provide verification of need.

   Pursuant to A.R.S. § 41-1027(H), an expedited rulemaking becomes effective immediately on filing with the Secretary of State.

   Council staff recommends approval of this rulemaking.
June 21, 2022

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: AHCCCS R9-31-101 et seq. Expedited Rulemaking

Dear Ms. Sornsin:

1. The close of record date: 6/10/2022
2. Explanation of how the expedited rule meets the criteria in A.R.S. 41-1027(A):
   Under A.R.S. 41-1027(A), this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated, and (7) implements, without material change, a course of action that is proposed in a five-year review report approved by the council pursuant to section 41-1056 within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the secretary of state.
3. Whether the rulemaking relates to a five-year-review report and, if applicable, the date the report was approved by the Council:
   The entirety of the rulemaking was approved by the Council in a five-year-review report on March 1, 2022.
4. A list of items enclosed:
   a. Notice of Final Expedited Rulemaking, including the preamble, table of contents, and text of each rule; and
   b. General and specific statutes authorizing the rules, including relevant statutory definitions.
Sincerely,

Kasey Rogg

Kasey Rogg
Assistant Director

Attachments
NOTICE OF FINAL EXPEDITED RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CHILDREN’S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:
   - R9-31-101 Amend
   - R9-31-103 Amend
   - R9-31-301 Amend
   - R9-31-308 Amend
   - R9-31-401 Amend
   - R9-31-1408 Amend
   - R9-31-1420 Amend

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):
   - Authorizing Statute: A.R.S. § 36-2986
   - Implementing Statute: A.R.S. § 36-2982

3. The effective date of the rule:
   The rule is effective the day the Notice of Final Expedited Rulemaking is filed with the Office of the Secretary of State.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:
   - Notice of Docket Opening: 28 A.A.R. 1236, June 3, 2022
   - Notice of Proposed Expedited Rulemaking: 28 A.A.R. 1219, June 3, 2022

5. The agency’s contact person who can answer questions about the rulemaking:
   - Name: Nicole Fries
   - Address: AHCCCS
   - Office of Administrative Legal Services
   - 801 E. Jefferson, Mail Drop 6200
   - Phoenix, AZ 85034
   - Telephone: (602) 417-4232
   - Fax: (602) 253-9115
   - E-mail: AHCCCSRules@azahcccs.gov
6. **An agency’s justification and reason why a rule should be made, amended, repealed, or renumbered to include an explanation about the rulemaking:**
Under A.R.S. 41-1027(A), this rulemaking does not increase the cost of regulatory compliance, increase a fee or reduce procedural rights of persons regulated and (7) Implements, without material change, a course of action that is proposed in a five-year review report approved by the council pursuant to section 41-1056 within one hundred eighty days of the date that the agency files the proposed expedited rulemaking with the secretary of state. The entirety of this rulemaking was approved by the Council in a five-year-review report on March 1, 2022.

AHCCCS seeks to remove outdated eligibility categories within R9-31-401 and R9-31-1408(D), in addition to updating the rules to reflect current timelines for both the period of ineligibility and the required timeline to provide verification of need. These and other technical and conforming changes are necessary to help members and potential members understand AHCCCS KidsCare categories and processes. Also, AHCCCS prefers to remove regulations with out-of-date references or eligibility categories in an effort to decrease the regulatory burden on the public. Additional changes are needed to keep the rules clear, concise, and understandable for members of the public.

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

8. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.

9. **A summary of the economic, small business, and consumer impact:**
Under A.R.S. § 41-1055(D)(2), the Administration is not required to provide an economic, small business, and consumer impact statement.

10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**
In R9-31-101, the symbol for section was added to citations to the United States Code in order to correctly format the citation. In R9-31-301, the headings were re-lettered correctly. No other differences between the proposed and final rulemakings.
11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:
No public comments were made.

12. 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:
There are no other matters prescribed by statutes applicable specifically to the Administration or this specific rulemaking.

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

   b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of the federal law:
      Not applicable.

   c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:
      No such analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:
None.

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:
Not applicable.

15. The full text of the rules follows:
TITLE 9. HEALTH SERVICES
CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CHILDREN’S HEALTH INSURANCE PROGRAM

Section
R9-31-101. Location of Definitions
R9-31-103. Eligibility and Enrollment Related Definitions Repealed
R9-31-301. Expenditure Limit and Enrollment
R9-31-308. Changes and Redeterminations
R9-31-401. KidsCare II Program Repealed
R9-31-1418. Discontinuance for Failure to Pay Premium
R9-31-1420. Payment of a Premium
## ARTICLE 1. DEFINITIONS

**R9-31-101. Location of Definitions**

A. Location of definitions. Definitions applicable to 9 A.A.C. 31 are found in the following:

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“TRBHA” or “Tribal Regional Behavioral Health Authority” R9-31-1201
“Tribal facility” A.R.S. § 36-2981
“Utilization management” R9-22-501
B. General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“ADHS” has the same meaning as in A.A.C. R9-22-102.

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

“Applicant” means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI medical coverage.

“Application” means an official request for Title XXI medical coverage made under this Chapter.

“Contract year” means the period beginning on October 1 and continuing until September 30 of the following year.

“Inpatient hospital services” means medically necessary services that require an inpatient stay in an acute care hospital and that are provided by or under the direction of a physician or other health care practitioner upon referral from a member’s primary care provider.

“Native American” means Indian as specified in 42 CFR 137.10.

“Seriously ill” means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

- Death,
- Disability,
- Disfigurement, or
- Dysfunction.

“Subcontractor” means a person, agency, or organization that enters into an agreement with a contractor or subcontractor to provide services.

R9-31-103. Eligibility and Enrollment-Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“CMDP” means Comprehensive Medical and Dental Program.

“CRS” means Children’s Rehabilitative Services.

“DES” means the Department of Economic Security.

“Determination” means the process by which an applicant is approved or denied for coverage.

“Enrollment” means the process by which a person is determined eligible for and enrolled in the program.

“Head of household” means the household member who assumes the responsibility for providing eligibility information for the household unit.

“Household income” means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.

“Information” means the knowledge received or communicated in written or oral form regarding a circumstance
or proof of a circumstance:

“PSP” means Premium Sharing Program, established according to A.R.S. § 36-2923.01.

“Redetermination” means the periodic review of a member’s continued Title XXI eligibility.

“Spouse” means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-31-301. Expenditure Limit and Enrollment

Expenditure limit and enrollment

+A. Title XXI will accept enrollees subject to the availability of federal funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.

+B. After the Administration has verified that federal funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.

+C. The Administration shall immediately stop processing all applications and shall provide advance notice to a member that the program will terminate under A.R.S. § 36-2985.

+D. A child is not entitled to a hearing under Chapter 34, if the program is suspended or terminated.

R9-31-308. Changes and Redeterminations

A. Reporting Changes. A member or a member's parent or guardian shall report the following changes to the Administration or its designee:

1. Any increase in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Any health coverage under private or group health insurance,
5. Employment of a member or a parent with a state agency,
6. Incarceration of a member, and
7. Any other changes that may impact eligibility or premiums.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility or premiums and is not received within 15 days, the Administration or its designee shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed enrollment period as specified in R9-31-307.

C. Redeterminations. The renewal eligibility requirements described under R9-22-306 for a KidsCare program member shall be followed.

D. Termination. The termination notice requirements as described under R9-22-307 for a KidsCare program member shall be followed.
ARTICLE 4. KIDSCARE II PROGRAM

R9-31-401. KidsCare II Program

A. Subject to CMS approval and the availability of funding under the special terms and conditions of the 1115 Waiver, the Administration shall establish the KidsCare II program.

B. Subject to the availability of funding, the following children are potentially eligible under this Section notwithstanding the closure of new enrollment under Article 3 on December 21, 2009, due to a lack of available funding:

1. Children with household income at or below 175% of FPL, who are discontinued for eligibility under 9 A.A.C. 22, Article 14, effective on or after May 1, 2012, due to age.

2. Children with household income at or below 175% of FPL, whose application for assistance was denied or discontinued as ineligible under 9 A.A.C. 22 on or after December 21, 2009, but who were determined potentially eligible for KidsCare as of the date of that denial or discontinuance and whose eligibility for KidsCare was not determined because the Administration stopped processing applications due to insufficient funding pursuant to R9-31-301(C).

3. Children not described in subsection (B)(2) with household income at or below 175% of FPL.

C. Beginning on or before May 1, 2012, the Administration shall send notice of potential eligibility under this Section to as many households with children described in subsection (B)(2) as is estimated by the Administration as likely to result in the return of a sufficient number of applications to increase enrollment under this Section to the extent of available funding under this Section.

D. Notice of potential eligibility:

1. Children who were placed on the waiting list established under R9-31-302(F) on an earlier date shall receive notice before children placed on the waiting list on a later date.

2. Notwithstanding subsection (D)(1), all children in the household will receive notice and be determined for eligibility based on the child in the household with the earliest applicable date.

3. Households shall have 30 days to return an application to the Department.

4. If notices that are initially sent under subsection (C) do not result in sufficient applications to enroll as many children as allowed by available funding, the Administration shall send out additional notices as described in subsection (C).

E. The Department shall review all applications for a determination of eligibility under 9 A.A.C. 22. If the Department determines that a child is not eligible under 9 A.A.C. 22 but has income at or below 175% of FPL and meets all other eligibility criteria under R9-31-302, the Department shall refer the application to the Administration.

F. The Administration shall accept the Department’s determinations regarding eligibility criteria without requiring the household to submit a new application under this Section or to reverify information verified by the Department.

G. Upon referral of an application from the Department, the Administration shall:
1. Determine whether the application referred by the Department was from a household with a child described in subsection (B)(1) or from a household that received a notice under subsection (D) that submitted an application to the Department within 30 days of the Administration’s request for a new application;

2. Process applications for children described in subsection (B)(3) beginning June 25, 2012;

3. Determine whether the household has any unpaid premiums as described in R9-31-1420 and, if so, the Administration shall require the household to pay the past due premium within 20 days from notification as a condition of determining a child eligible under this Section;

4. Enroll children under this Section based on the date that the Administration determines the child eligible; and

5. Stop processing applications and determining eligibility under this Section once the Administration has enrolled the maximum number of children consistent with funding made available under this Section.

H. Effective date of initial enrollment.

1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.

2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.

I. Any child who is not determined eligible under subsection (G) shall remain on the waiting list described in R9-31-302(F).

J. Eligibility for children under this Section ends on December 31, 2013.

K. Except as otherwise provided by this Section, eligibility shall be determined in accordance with the provisions of this Chapter.
ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3

R9-31-1418. Discontinuance for Failure to Pay Premium

A. Discontinuance notice. The Administration shall send an adverse action notice to discontinue eligibility if the Administration does not receive the past and current due premium amounts by the 15th day of the current month. The Administration shall follow the discontinuance notice requirements under R9-31-310(B).

B. Discontinuance rescinded. The Administration shall rescind the discontinuance and continue eligibility if the past due amount for at least one prior month is received by the Administration in full before the effective date of the discontinuance.

C. Discontinuance of eligibility. Except as provided in R9-31-1419, the Administration shall discontinue eligibility on the effective date of the discontinuance if the past due amount for at least one prior month is not received by the Administration in full before the effective date of the discontinuance.

D. Notwithstanding subsection (A), the Administration shall not discontinue eligibility for the enrolled members of the household until the Administration has not received, by the 15th day of the month in which the Administration sends the adverse action notice, premium amounts due for the past two months and the current month for persons who:
   1. Have been continuously eligible since June 2004,
   2. Were required to pay a premium under R9-31-1402(B) for the month of July 2004,
   3. Were required to pay any premium under R9-31-1402 for the month of August 2004, and

R9-31-1420. Payment of a Premium

When a member was discontinued with an unpaid premium, the parent or other responsible person shall pay the past due premium amounts for a child to the Administration or the child will remain ineligible for 90 days before the person can attain eligibility again.
Arizona Administrative Code
Title 9, Ch. 31

Arizona Health Care Cost Containment System – Children’s Health Insurance Program

TITLE 9. HEALTH SERVICES
CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CHILDREN’S HEALTH INSURANCE PROGRAM

Editor’s Note: The Office of the Secretary of State publishes all Chapters on white paper (Supp. 01-3).

Editor’s Note: Articles 1 through 13, and Article 16 were adopted under an exemption from the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6) pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session. Although exempt from certain provisions of the rulemaking process, AHCCCS submitted a notice of docket opening with the Secretary of State for publication in the Arizona Administrative Register. Exemption from A.R.S. Title 41, Chapter 6 means AHCCCS was not required to submit these rules to the Governor’s Regulatory Review Council for review; they did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and they were not required to hold public hearings on these rules. Because this Chapter contains rules that are exempt from the regular rulemaking process, it is printed on blue paper.

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R9-31-102. Scope of Services-related Definitions
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Article 4, consisting of Section R9-31-401, made by exempt rulemaking at 18 A.A.R. 1141, effective May 1, 2012 (Supp. 12-2).

Article 4, consisting of Sections R9-31-401 through R9-31-407, repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).


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ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).


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Article 9, consisting of Section R9-31-901, adopted effective October 23, 1998, under an exemption from the Administrative Procedure Act. (Supp. 98-4).

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R9-31-1206. Repealed
R9-31-1207. Repealed
R9-31-1208. Repealed

ARTICLE 13. REPEALED


ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3

Article 14, consisting of Sections R9-31-1401 through R9-31-1406, adopted effective September 10, 1999, under an exemption from the Administrative Procedure Act (Supp. 99-3).

ARTICLE 15. RESERVED

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Article 17, consisting of Sections R9-31-1701 through R9-31-1713 and Sections R9-31-1716 through R9-31-1732, repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).
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**Notes:**
- “Inmate of a public institution” [42 CFR 435.1010](#)
- “Inpatient hospital services” [R9-31-101](#)
- “License” or “licensure” [R9-22-101](#)
- “Medical record” [R9-22-101](#)
- “Medical review” [R9-31-107](#)
- “Medical services” [R9-22-101](#)
- “Medical supplies” [R9-22-102](#)
- “Member” [A.R.S. § 36-2981](#)
- “Native American” [R9-31-101](#)
- “New hospital” [R9-22-701](#)
- “NF” or “nursing facility” [42 U.S.C. 1396v(a)](#)
- “NICU” [R9-22-701](#)
- “Noncontracting provider” [A.R.S. § 36-2981](#)
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- “Practitioner” [R9-22-102](#)
- “Pre-existing condition” [R9-31-501](#)
- “Prepaid capitated” [A.R.S. § 36-2981](#)
- “Prescription” [R9-22-102](#)
- “Primary care physician” [A.R.S. § 36-2981](#)
- “Primary care practitioner” [A.R.S. § 36-2981](#)
- “Primary care provider (PCP)” [R9-22-102](#)
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- “Prior authorization” [R9-22-102](#)
- “Program” [A.R.S. § 36-2981](#)
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- “Provider” [A.R.S. § 36-2931](#)
- “Psychiatric” [A.R.S. § 36-501](#)
- “Psychologist” [A.R.S. § 36-501](#)
- “Psychosocial rehabilitation” [R9-22-102](#)
- “Qualified alien” [A.R.S. § 36-2903.03](#)
- “Qualifying plan” [A.R.S. § 36-2981](#)
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- “Radiology” [R9-22-102](#)
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- “Redetermination” [R9-31-103](#)
- “Referral” [R9-22-101](#)
- “Regional Behavioral Health Authority” [A.R.S. § 36-3401](#)
- “RBHA” [R9-22-102](#)
- “Reimbursement services” [R9-22-102](#)
- “Remittance advice” [R9-22-701](#)
- “RFP” [R9-31-106](#)
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- “Scope of services” [R9-22-102](#)
- “Seriously ill” [R9-31-101](#)
- “Service location” [R9-22-101](#)
- “Service site” [R9-22-101](#)
- “SMI” or “Seriously mentally ill” [A.R.S. § 36-550](#)
- “Specialist” [R9-22-102](#)
- “Speech therapy” [R9-22-102](#)
B. General definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“ADHS” has the same meaning as in A.A.C. R9-22-102.

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

“Applicant” means a person who submits, or whose representative submits, a written, signed, and dated application for Title XXI medical coverage.

“Application” means an official request for Title XXI medical coverage.

“Contract year” means the period beginning on October 1 and continuing until September 30 of the following year.

“Inpatient hospital services” means medically necessary services that require an inpatient stay in an acute care hospital and that are provided by or under the direction of a physician or other health care practitioner upon referral from a member’s primary care provider.

“Native American” means Indian as specified in 42 CFR 137.10.

“Seriously ill” means a medical or psychiatric condition manifesting itself by acute symptoms that left untreated may result in:

- Death
- Disability
- Disfigurement
- Dysfunction

“Subcontractor” means a person, agency, or organization that enters into an agreement with a contractor or subcontractor to provide services.

Historical Note

R9-31-102. Scope of Services-related Definitions
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Certified nurse practitioner” means a registered nurse practitioner as certified by the Arizona Board of Nursing according to A.R.S. Title 32, Ch. 15.

“Psychosocial rehabilitation services” means the same as in R9-22-102.

Historical Note

R9-31-103. Eligibility and Enrollment Related Definitions
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“CMDP” means Comprehensive Medical and Dental Program.

“CRS” means Children’s Rehabilitative Services.

“DES” means the Department of Economic Security.

“Determination” means the process by which an applicant is approved or denied for coverage.

“Enrollment” means the process by which a person is determined eligible for and enrolled in the program.

“Head of household” means the household member who assumes the responsibility for providing eligibility information for the household unit.

“Household income” means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as defined in R9-31-304.

“Information” means the knowledge received or communicated in written or oral form regarding a circumstance or proof of a circumstance.

“PSP” means Premium Sharing Program, established according to A.R.S. § 36-2923.01.

“Redetermination” means the periodic review of a member’s continued Title XXI eligibility.

“Spouse” means the husband or wife of a Title XXI applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.


Historical Note
Definitions. The words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. “Offeror” means a person or other entity that submits a proposal to the Administration in response to an RFP.
2. “Proposal” means all documents including best and final offers submitted by an offeror in response to a Request for Proposals by the Administration.
3. “RFP” means Request for Proposals including all documents, whether attached or incorporated by reference, which are used by the Administration for soliciting a proposal according to this Article.

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children’s Health Insurance Program under A.R.S. § 36-2982.

B. Scope of services for American Indian fee-for-service members is under Article 16 of this Chapter.

C. A contractor or RBHA shall provide behavioral health services under Articles 12 and 16.

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

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. The Administration or a contractor may waive the covered services referral requirements of this Article.
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology provid-
ers within the contractor’s network without a referral from a primary care provider.

5. A member may receive behavioral health services as specified in 9 A.A.C. 22, Articles 2 and 12.

6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.

7. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.

8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
   a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
   b. Services or items furnished gratuitously; and
   c. Personal care items, except as specified in R9-31-212.

9. Medical or behavioral health services are not covered if provided to:
   a. An inmate of a public institution;
   b. A person who is a resident of an institution for the treatment of tuberculosis; or
   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

E. The Administration or a contractor may deny payment if a provider fails to obtain prior authorization as specified in this Article and Article 7 of this Chapter for non-emergency services. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside of the GSA only if one of the following applies:
   1. A member is referred by a primary care provider for medical specialty care out of the contractor’s area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for the member;
   2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member’s family; or
   3. The contractor authorizes placement in a nursing facility located outside of the GSA;

H. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.
   1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
   2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

Historical Note
R9-31-205. Attending Physician, Practitioner, and Primary Care Provider Services
A. A primary care provider shall provide primary care provider services within the provider’s scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:
1. Periodic health examination and assessment,
2. Evaluation and diagnostic workup,
3. Medically necessary treatment,
4. Prescriptions for medication and medically necessary supplies or equipment,
5. Referral to a specialist or other health care professional if medically necessary as specified in A.R.S. § 36-2989,
6. Patient education,
7. Home visits if medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.
B. As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgery. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery for the member.
C. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider are limited to the services or conditions for which the referral is made, or for which authorization is given by the contractor;
2. A member’s physical examination is not a covered service if the physical examination is to obtain one or more of the following:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot’s examination (Federal Aviation Administration),
   e. Disability certification to establish any kind of periodic payments,
   f. Evaluation to establish third-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
3. The following services are excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgery;
   b. Pregnancy termination counseling services;
   c. A pregnancy termination, unless authorized under federal law;
   d. A service or item furnished solely for cosmetic purposes;
   e. A hysterectomy, unless determined to be medically necessary; and
   f. Licensed midwife services for prenatal care and home birth.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

R9-31-206. Organ and Tissue Transplantation Services
The following organ and tissue transplantation services shall be covered for a member as specified in A.R.S. § 36-2989 if prior authorized and coordinated with a member’s contractor:
1. Kidney transplantation;
2. Simultaneous Kidney/Pancreas transplant;
3. Cornea transplantation;
4. Heart transplantation;
5. Liver transplantation;
6. Autologous and allogeneic bone marrow transplantation;
7. Lung transplantation;
8. Heart-lung transplantation;
9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met; and
10. Immunosuppressant medications, chemotherapy, and other related services.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4).

R9-31-207. Dental Services
Medically necessary dental services are provided for children under age 19 under A.R.S. § 36-2989 and R9-22-213.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

R9-31-208. Laboratory, Radiology, and Medical Imaging Services
An AHCCCS-registered provider shall provide laboratory, radiology, and medical imaging services for children under age 19, under A.R.S. § 36-2989 and R9-22-208.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

R9-31-209. Pharmaceutical Services
Pharmaceutical services are provided for children under age 19 under R9-22-209.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2).

R9-31-210. Emergency Medical Services
A. Emergency medical services shall be provided based on the prudent layperson standard to a member by licensed providers registered with AHCCCS to provide services under A.R.S. § 36-2989.
B. The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor or a RBHA for a member and to determine the party responsible for payment of services rendered.
C. Access to an emergency room and emergency medical services shall be available 24 hours per day, seven days per week in
Each contractor’s service area. The use of examining or treatment rooms shall be available whenever required by a physician or practitioner for the provision of emergency services.

D. Behavioral Health Evaluation provided by a psychiatrist or psychologist shall be covered as an emergency service, so long as it meets the requirements of 9 A.A.C. 31, Article 12.

E. Emergency services do not require prior authorization but providers shall comply with the following notification requirements:

1. Providers and noncontracting providers furnishing emergency services to a member shall notify the member’s contractor within 12 hours of the time the member presents for services;
2. If a member’s medical condition is determined not to be an emergency medical condition under Article 1 of this Chapter, the provider shall notify the member’s contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member’s nonemergency condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

F. A provider and a noncontracting provider shall request authorization from a contractor for post stabilization services. A contractor shall pay for the post stabilization services if:

1. The service is pre-approved by a contractor, or
2. A contractor does not respond to an authorization request within the time-frame under 42 CFR 438.114.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 7 A.A.R. 4740, effective October 1, 2001 (Supp. 01-3).

R9-31-211. Transportation Services
The Administration shall provide transportation services under A.A.C. R9-22-211.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4).

R9-31-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies
As specified in A.R.S. § 36-2989, DME, orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with requirements of this Chapter and A.A.C. R9-22-212. For purposes of this Section, where the term “AHCCCS services” is used in R9-22-212, it is replaced with the term “Title XXI services.”

Historical Note

R9-31-213. Health Risk Assessment and Screening Services
A. As authorized by A.R.S. § 36-2989, the following services shall be covered for a member:

1. Screening services, including:
   a. Comprehensive health, behavioral health and developmental histories;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history; and
   d. Health education, including anticipatory guidance.

2. Vision services including:
   a. Diagnosis and treatment for defects in vision,
   b. Eye examinations for the provision of prescriptive lenses, and
   c. Provision of prescriptive lenses.

3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing,
   b. Testing to determine hearing impairment, and
   c. Provision of hearing aids.

B. All providers of services shall meet the following standards:

1. Provide services by or under the direction of the member’s primary care provider or dentist.
2. Perform tests and examinations as specified in contract and under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments.
3. Refer members as necessary for behavioral health evaluation and treatment services as specified in 9 A.A.C. 31, Article 12.
4. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.

C. A contractor shall meet the following additional conditions for members:

1. Provide information to members and their parents or guardians concerning services; and
2. Notify members and their parents or guardians regarding the initiation of screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule.

D. A contractor, primary care provider, attending physician, or practitioner shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

Historical Note

R9-31-214. Reserved

R9-31-215. Other Medical Professional Services
A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting:

1. Dialysis;
2. The following family planning services if provided to delay or prevent pregnancy:
   a. Medications,
   b. Supplies,
   c. Devices, and
   d. Surgical procedures.
3. Family planning services are limited to:
   a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package
of sexually transmitted disease tests provided with a family planning service; and
b. Natural family planning education or referral;
4. Midwifery services provided by a nurse practitioner certified in midwifery;
5. Podiatry services if ordered by a member’s primary care provider as specified in A.R.S. § 36-2989;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services in A.R.S. § 36-2989;
9. Private or special duty nursing services;
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiologic services provided under this Article;
11. Total parenteral nutrition services, (which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract);
12. Inpatient chemotherapy;
13. Outpatient chemotherapy; and

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (11) and (14); except for:
1. Dialysis shunt placement,
2. Arteriovenous graft placement for dialysis,
3. Angioplasties or thrombectomies of dialysis shunts,
4. Angioplasties or thrombectomies of arteriovenous grafts for dialysis,
5. Eye surgery for the treatment of diabetic retinopathy,
6. Eye surgery for the treatment of glaucoma,
7. Eye surgery for the treatment of macular degeneration,
8. Home health visits following an acute hospitalization (limited up to five visits),
9. Hysteroscopies, (up to two, one before and one after, when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization),
10. Physical therapy subject to the limitation in subsection A.A.C. R9-22-215(C),
11. Facility services related to wound debridement,
12. Apnea management and training for premature babies up to the age of 1, and
13. Other services identified by the Administration through the Provider Participation Agreement.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-216. NF, Alternative HCBS Setting, or HCBS
Services provided in a NF, including room and board, alternative HCBS setting, or HCBS shall be covered as specified in A.A.C. R9-22-216.

Historical Note

ARTICLE 3. ELIGIBILITY AND ENROLLMENT
R9-31-301. Expenditure Limit and Enrollment
Expenditure limit and enrollment
1. Title XXI will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2985.
2. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2985.
3. The Administration shall immediately stop processing all applications and shall provide advance notice to a member that the program will terminate under A.R.S. § 36-2985.
4. A child is not entitled to a hearing under Chapter 34, if the program is suspended or terminated.

Historical Note

R9-31-302. General Requirements
A. Administration. The Administration or its designee shall administer the program as specified in A.R.S. § 36-2982. The requirements described under Chapter 22, Article 3, except for R9-22-303, R9-22-305(1), R9-22-306(A)(4)(a) and (b), R9-22-306(B)(2)(b) and (c), R9-22-306(B)(3)(c)(iv), (vii) and (xi), R9-22-306(B)(4), R9-22-306(B)(5) and R9-22-307, apply to this Chapter.
B. Eligibility determination processing time. When an application is complete, the Administration or its designee shall mail notification to the applicant regarding the eligibility determination no more than 30 days from the date of application except when there is an emergency beyond the Administration’s or its designee’s control.

Historical Note

R9-31-303. Eligibility Criteria
Eligibility. To be eligible for the program, an applicant shall meet all the following eligibility requirements in addition to R9-31-302:
1. Age. Is less than 19 years of age. A child's coverage shall continue through the month in which a child turns age 19 if the child is otherwise eligible;
2. Income. Meets the income requirements in R9-31-304;
3. Cost sharing. Pays the cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2982 and 36-2903.01;
4. Other federal program. Is not eligible for Medicaid or other federally operated or financed health care insurance program, except the Indian Health Service as specified in A.R.S. § 36-2983;
B. Calculating monthly income. The Administration or its designee shall calculate monthly income under R9-22-1423.

C. The Administration or its designee shall include the income of persons described under R9-22-1420(B).

D. Income disregards. When determining gross income of the household, the Administration or its designee shall disregard income as described under R9-22-1421(A).

E. Effective date of initial eligibility.
1. For an eligibility determination completed by the 25th day of the month, eligibility shall begin on the first day of the month following the determination of eligibility.
2. For an eligibility determination completed after the 25th day of the month, eligibility shall begin on the first day of the second month following the determination of eligibility.

Historical Note

R9-31-305. Verification

Verification. An applicant or a member shall provide the Administration or its designee with verification or authorize the release of verification to the Administration or its designee of all information necessary to complete the determination of eligibility as described under R9-22-304.

Historical Note

R9-31-306. Enrollment

Enrollment requirements applicable to the KidsCare program are described under Chapter 22, Article 17.

Historical Note

R9-31-307. Guaranteed Enrollment

A. Guaranteed Enrollment. A child who is determined eligible for Title XXI shall be guaranteed a one-time, 12-month period of continuous coverage unless a child:
1. Attains age 19,
2. Is no longer a resident of the state,
3. Is an inmate of a public institution,
4. Is determined to have been ineligible at the time of approval,
5. Obtains private or group health coverage,
6. Is adopted and the new household does not meet the qualifications of this program,
7. Is a patient in an institution for mental diseases,
8. Has whereabouts that are unknown, or
9. Has a head of household who:
   a. Does not pay cost sharing premium amount when premiums are required as specified in A.R.S. §§ 36-2981 for the Title XXI household income group size.
R9-31-308. Changes and Redeterminations

A. Reporting Changes. A member or a member’s parent or guardian shall report the following changes to the Administration or its designee:
   1. Any increase in income that will begin or continue into the following month,
   2. Any change of address,
   3. The addition or departure of a household member,
   4. Any health coverage under private or group health insurance,
   5. Employment of a member or a parent with a state agency,
   6. Incarceration of a member, and
   7. Any other changes that may impact eligibility or premiums.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility or premiums and is not received within 10 days, the Administration or its designee shall send a notice to discontinue eligibility for a member unless a member is within the guaranteed enrollment period as specified in R9-31-307.

C. Redeterminations. The renewal eligibility requirements described under R9-22-306 for a KidsCare program member shall be followed.

D. Termination. The termination notice requirements as described under R9-22-307 for a KidsCare program member shall be followed.

R9-31-309. Newborn Eligibility

A. Eligibility. A child born to a Title XXI member, is eligible for 12 months of coverage without filing an application under Title XXI provided:
   1. The child continues to live with the child's mother during the 12-month period; and
   2. One of the events as specified in R9-31-307(A) does not occur.

B. Deemed Coverage. A newborn's deemed newborn coverage shall begin effective with a newborn's date of birth and end with the last day of the month in which a newborn turns age 1. Deemed newborn status does not preclude a child from being approved for Title XIX.

C. Enrollment choice for a newborn. A newborn shall be enrolled with a mother's enrollment choice as specified in contract.

D. Notification of enrollment. The Administration or its designee shall notify a mother of a newborn's enrollment and provide a mother an opportunity to select an enrollment choice as specified in Chapter 22, Article 17.

R9-31-310. Notice Requirements

Notice Requirements. The notice requirements as described in R9-22-312 apply to this Chapter.

R9-31-311. Children's Rehabilitative Services (CRS) Eligibility Requirements

Beginning October 1, 2013, an enrolled KidsCare member who is determined to need active treatment for one or more of the qualifying medical condition(s) in R9-22-1303 shall be enrolled with the CRS contractor as described under Chapter 22, Article 13.

R9-31-401. KidsCare II Program

A. Subject to CMS approval and the availability of funding under the special terms and conditions of the 1115 Waiver, the Administration shall establish the KidsCare II program.

B. Subject to the availability of funding, the following children are potentially eligible under this Section notwithstanding the closure of new enrollment under Article 3 on December 21, 2009, due to a lack of available funding:
   1. Children with household income at or below 175% of FPL, who are discontinued for eligibility under 9 A.A.C. 22 on or after December 21, 2009, but who where determined potentially eligible for KidsCare as of the date of that denial or discontinuance and whose eligibility for KidsCare was not determined because the Administration stopped processing applications due to insufficient funding pursuant to R9-31-301(C).
   2. Children not described in subsection (B)(2) with household income at or below 175% of FPL.
   3. Children not described in subsection (B)(2) with household income at or below 175% of FPL.
return of a sufficient number of applications to increase enrollment under this Section to the extent of available funding under this Section.

D. Notice of potential eligibility:
1. Children who were placed on the waiting list established under R9-31-302(F) on an earlier date shall receive notice before children placed on the waiting list on a later date.
2. Notwithstanding subsection (D)(1), all children in the household will receive notice and be determined for eligibility based on the child in the household with the earliest applicable date.
3. Households shall have 30 days to return an application to the Department.
4. If notices that are initially sent under subsection (C) do not result in sufficient applications to enroll as many children as allowed by available funding, the Administration shall send out additional notices as described in subsection (C).
5. If notices that are initially sent under subsection (C) do not result in sufficient applications to enroll as many children as allowed by available funding, the Administration shall send out additional notices as described in subsection (C).

E. The Department shall review all applications for a determination of eligibility under 9 A.A.C. 22. If the Department determines that a child is not eligible under 9 A.A.C. 22 but has income at or below 175% of FPL and meets all other eligibility criteria under R9-31-303, the Department shall refer the application to the Administration.

F. The Administration shall accept the Department’s determinations regarding eligibility criteria without requiring the household to submit a new application under this Section or to reverify information verified by the Department.

G. Upon referral of an application from the Department, the Administration shall:
1. Determine whether the application referred by the Department was from a household with a child described in subsection (B)(1) or from a household that received a notice under subsection (D) that submitted an application to the Department within 30 days of the Administration’s request for a new application;
2. Process applications for children described in subsection (B)(3) beginning June 25, 2012;
3. Determine whether the household has any unpaid premiums as described in R9-31-1420 and, if so, the Administration shall require the household to pay the past due premium within 20 days from notification as a condition of determining a child eligible under this Section;
4. Enroll children under this Section based on the date that the Administration determines the child eligible; and
5. Stop processing applications and determining eligibility under this Section once the Administration has enrolled the maximum number of children consistent with funding made available under this Section.

H. Effective date of initial enrollment.
1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.

I. Any child who is not determined eligible under subsection (G) shall remain on the waiting list described in R9-31-302(F).

J. Eligibility for children under this Section ends on December 31, 2013.

K. Except as otherwise provided by this Section, eligibility shall be determined in accordance with the provisions of this Chapter.

Historical Note

R9-31-402. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

R9-31-403. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

R9-31-404. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

R9-31-405. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

R9-31-406. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

R9-31-407. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1).

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Definitions. In this Chapter, unless the context explicitly requires another meaning terms are defined in R9-31-101 or cross-referenced to the location of the definition.
R9-31-502. Pre-existing Conditions
A contractor shall comply with the pre-existing condition requirements in A.A.C. R9-22-502.

R9-31-503. Repealed

R9-31-504. Marketing; Prohibition Against Inducements; Misrepresentations; Discrimination; Sanctions
A contractor or any person or entity acting as the contractor’s marketing representative shall follow the requirements in A.A.C. R9-22-504.

R9-31-505. Repealed

R9-31-506. Reserved

R9-31-507. Repealed

R9-31-508. Repealed

R9-31-509. Transition and Coordination of Member Care
The Administration or a contractor shall conduct transition and coordination of member care as described in A.A.C. R9-22-509.

R9-31-510. Repealed

R9-31-511. Repealed

R9-31-512. Release of Safeguarded Information
The Administration, a contractor, provider, and noncontracting provider shall meet the requirements specified in A.A.C. R9-22-512 regarding release of safeguarded information for an applicant or member.

R9-31-513. Repealed

R9-31-514. Repealed
R9-31-525. Reserved

ARTICLE 6. RFP AND CONTRACT PROCESS


A. The Director has full operational authority to adopt rules and to use the appropriate rules for contract administration and oversight of contractors under A.R.S. § 36-2986. The Administration shall administer the program under A.R.S. § 36-2986.

B. The Administration shall award contracts under A.R.S. § 36-2986 to provide services under A.R.S. § 36-2986.

C. The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, unless otherwise specified in this Chapter.

D. The Administration is exempt from the procurement code under A.R.S. § 36-2986 and 41-2501.

E. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2986 and dispose of the records under A.R.S. § 41-2550.

R9-31-602. RFP

The RFP for a contractor serving members who qualify for the program shall be under A.R.S. § 36-2986 and A.A.C. R9-22-602.

R9-31-603. Contract Award

The contract award shall be under A.R.S. § 36-2986 and A.A.C. R9-22-603.

R9-31-604. Contract or Proposal Protests; Appeals

Contract or proposal protests or appeals shall be under A.A.C. R9-22-604.

R9-31-605. Waiver of Contractor’s Subcontract with Hospitals

A waiver of a contractor’s subcontract with a hospital shall be under A.A.C. R9-22-605.

R9-31-606. Contract Compliance Sanction

The Administration shall follow sanction provisions under A.A.C. R9-22-606.
ARTICLE 7. STANDARDS FOR PAYMENTS

R9-31-701. Standards for Payments Related Definitions

Definitions. The words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for Title XXI-covered services that meet medical review criteria of the Administration or contractor.

“Medical review” means a review involving clinical judgment of a claim or a request for a service before or after it is paid or rendered to ensure that the services provided to the member are medically necessary and covered services and that the provider obtains required authorizations. The criteria for medical review are established by the contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Outlier” means a hospital claim or encounter in which the Title XXI inpatient hospital days of care have operating costs per day that meet the criteria in A.A.C. R9-22-712.

“Tiered per diem” means a payment structure in which payment is made on a per-day basis depending upon the tier into which the Title XXI inpatient hospital day of care is assigned.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 452, effective January 10, 2002 (Supp. 02-1). Section repealed; new Section made by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

R9-31-701.10. General Requirements

The following Sections of A.A.C. Chapter 22, Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to a member under the KidsCare program, except that the term “Children’s Health Insurance Program Fund” shall be substituted for “AHCCCS fund” and “A.R.S. § 36-2986” shall be substituted for “A.R.S. § 36-2903”:

1. Scope of the Administration’s and Contractor’s Liability, R9-22-701.10;
2. Charges to Members, R9-22-702;
3. Payments by the Administration and Payments by Contractors, R9-22-703 and R9-22-705;
4. Payments for Newborns, R9-22-707;
5. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
6. Payments for Non-hospital Services, R9-22-710;
7. Copayments, R9-22-711;
8. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01(10) and Article 2;
9. Overpayment and Recovery of Indebtedness, R9-22-713;
10. Payments to Providers, R9-22-714;
11. Hospital Rate Negotiations, R9-22-715;
12. Contractor Performance Measure Outcomes, R9-22-719; and

Historical Note

New Section made by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).
ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-31-801 through R9-31-803 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).
repealed by final rulemaking at 10 A.A.R. 822, effective April 3, 2004 (Supp. 04-1).

ARTICLE 9. REPEALED

R9-31-901. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 12 A.A.R. 4494, effective January 6, 2007 (Supp. 06-4).

ARTICLE 10. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-31-1001. Definitions
The definitions in A.R.S. § 36-2981, A.A.C. R9-22-1001, and A.A.C. R9-31-101 apply to this Article.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1002. General Provisions
AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1003. Cost Avoidance
The provisions in A.A.C. R9-22-1003 apply to this Section except:
1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2; and
2. This Section applies to Title XXI covered services.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1004. Member Participation
The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1005. Collections
The provisions in A.A.C. R9-22-1005 apply to this Section except:
1. Replace the reference to “Article 2,” with 9 A.A.C. 31, Article 2;
2. This Section applies to Title XXI fee-for-service and reinsurance payments.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1152, effective May 1, 2004 (Supp. 04-1).

R9-31-1006. AHCCCS Monitoring Responsibilities
With the exception of long-term care insurance, the provisions in A.A.C. R9-22-1006 apply to this Section.

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-31-1101. Basis for Civil Monetary Penalties and Assessments
AHCCCS shall use the provisions in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, and penalties and assessments.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1102. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1103. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

R9-31-1104. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 10 A.A.R. 3067, effective September 11, 2004 (Supp. 04-3).

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-31-1201. Requirements
The requirements, services and definitions under Chapter 22, Article 2 and Article 12 apply to behavioral health services provided under this Article.
This Article contains the requirements for the payment of a premium by the Administration to the Administration by a member and the processing of a premium for a child determined eligible under Article 3 of this Chapter.

**R9-31-1401. Purpose**

This Article contains the requirements for the payment of a premium for a child determined eligible under Article 3 of this Chapter to the Administration by a member and the processing of a premium by the Administration.

**ARTICLE 14. PREMIUMS FOR A CHILD DETERMINED ELIGIBLE UNDER ARTICLE 3**

**R9-31-1402. Premium Amount for a Member who is a Child Determined Eligible Under Article 3 of this Chapter**

A. For the purposes of this Article, a premium is a monthly amount that an enrolled member pays to the Administration to remain eligible for Title XXI.

B. When the household income is greater than the income limit described under R9-22-1427(D) and less than or equal to 150 percent of the FPL, the monthly premium is $10 for one eligible child and $15 for two or more eligible children.

C. When household income is greater than 150 percent of the FPL and less than or equal to 175 percent of the FPL, the monthly premium payment is $40 for one eligible child and $60 for two or more eligible children.

D. When household income is greater than 175 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium is $50 for one eligible child and $70 for two or more eligible children.

E. A household’s premium payments as specified in this Section shall not exceed five percent of a household’s gross income.

F. A member’s newborn is enrolled immediately upon the Administration receiving notification of the child’s birth. Upon enrollment, the household’s premium is redetermined.

G. To remain eligible, the premium amount shall be paid according to this Article.

H. American Indians are exempt from paying premiums.

**Historical Note**


**New Section adopted by exempt rulemaking at 5 A.A.R. 3670, effective September 10, 1999 (Supp. 99-3). Section repealed; new Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Amended by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).**

**R9-31-1403. Repealed**

**Historical Note**


**R9-31-1404. Hardship Exemption for a Member who is a Child Determined Eligible Under Article 3 of this Chapter**

A. Definitions. The following definitions apply to this Section:

1. “Major expense” means the expense is more than 10 percent of the household’s countable income under R9-31-304.
2. “Medically necessary” has the same meaning as defined in A.A.C. R9-22-101.

B. Hardship exemption. The Administration shall provide information to the head of household regarding the request for a hardship exemption. The Administration shall grant a hardship exemption from the disenrollment requirements under A.R.S. §36-2982 for a household who:
1. Is no longer able to pay the premium due to one of the hardship criteria in subsection (C), and
2. Submits a written request for a hardship exemption and provides all necessary written information at the time of request.

C. Hardship criteria. To be eligible for a hardship exemption, a household shall have:
1. Medically necessary expenses or health insurance premiums that:
   a. Are not covered under Medicaid or other insurance, and
   b. Exceed 10 percent of the household’s countable income under R9-31-304;
2. Unanticipated major expense, related to maintaining a residence for the household or transportation for work;
3. A combination of medically necessary expenses under subsection (C)(1) and unanticipated major expenses under subsection (C)(2) that exceed 10 percent of the household’s countable income under R9-31-304; or
4. Experienced the death of a household member during the month the premium was not paid.

D. Written hardship exemption request. The Administration shall not consider a hardship exemption unless the Administration receives the written request and information under subsection (C) by the due date specified in the Administration’s notice that explains the undue hardship exemption requirements.

E. Notification. The Administration shall notify the head of household of the approval or denial of the request for exemption and discontinuance under R9-31-310, no later than 10 days from the date the Administration received the request.

F. Appeal and Request for hearing. The head of household may appeal and request a hearing concerning the discontinuance and denial of the hardship exemption.

Historical Note

R9-31-1407. Repealed

Historical Note
Renumbered from R9-31-1406 and amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1408. Repealed

Historical Note

R9-31-1409. Payment Due Date for Current Month
The monthly premium payment is due on the 15th day of the month for coverage of that month. This would be considered a current payment.

Historical Note

R9-31-1410. Payment Received Date
A payment is considered received on the date that the Administration receives and credits the payment to the member’s account.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1411. Past Due Payment
A. Past due payment date. A payment is considered past due if the Administration receives the payment after the 15th day of the month.

B. Payment not received. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the past and current due amounts in the next billing statement.

Historical Note

R9-31-1412. Payment Type
A premium shall be paid to the Administration by a:
1. Cashier’s check,
2. Personal check,
3. Money order,
4. Electronic debit, or
5. Other form approved by the Administration.

Historical Note
R9-31-1413. Returned Check
The Administration shall not accept a personal check when the pre-
mium has been previously paid with a personal check that was
returned to the Administration because of insufficient funds.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1414. Payment In Advance
A premium may be paid in advance.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1415. Reimbursement of a Premium
A. A premium paid in advance is nonrefundable, unless the mem-
ber is disenrolled at least 15 days prior to the month of cover-
age.
B. A premium paid during an appeal and request for hearing pro-
cess is applied as specified in R9-31-1419.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1416. Allocation of Payment for an Eligible Member
Except for payments specified in R9-31-1419 of this Article, all
payments received for eligible members shall first be applied to any
past due amounts for prior months owed to the Administration for a
child determined eligible under Article 3 of this Chapter. Any
remaining amounts shall then be applied to the amount due for the
current month for a child eligible under Article 3 of this Chapter.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4). Amended
by exempt rulemaking at 9 A.A.R. 4560, effective Octo-
ber 1, 2003 (Supp. 03-4). Amended by exempt rule-
making at 11 A.A.R. 477, effective January 1, 2005 (Supp.
04-4).

R9-31-1417. Change in Premium Amount
A. When there is a decrease in the premium amount and the
change is processed by the 25th day of the month, then the
effective date of the change shall begin on first day following
the month in which the amount of the premium change is pro-
cessed.
B. When there is a decrease in the premium amount and the
change is processed after the 25th day of the month, then the
effective date of the change shall begin on the first day of the
second month in which the amount of the premium change is
processed.
C. When there is an increase in the premium amount, the effec-
tive date of the change shall begin with the first month follow-
ing advance notice of at least ten days.

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4). Amended
by exempt rulemaking at 11 A.A.R. 477, effective Janu-
ary 1, 2005 (Supp. 04-4).

R9-31-1418. Discontinuance for Failure to Pay Premium
A. Discontinuance notice. The Administration shall send an
adverse action notice to discontinue eligibility if the Adminis-
tration does not receive the past and current due premium
amounts by the 15th day of the current month. The Adminis-
tration shall follow the discontinuance notice requirements
under R9-31-310(B).
B. Discontinuance rescinded. The Administration shall rescind
the discontinuance and continue eligibility if the past due
amount for at least one prior month is received by the Admin-
istration in full before the effective date of the discontinuance.
C. Discontinuance of eligibility. Except as provided in R9-31-
1419, the Administration shall discontinue eligibility on the
effective date of the discontinuance if the past due amount for
at least one prior month is not received by the Administration
in full before the effective date of the discontinuance.
D. Notwithstanding subsection (A), the Administration shall not
discontinue eligibility for the enrolled members of the house-
hold until the Administration has not received, by the 15th day
of the month in which the Administration sends the adverse
action notice, premium amounts due for the past two months
and the current month for persons who:
1. Have been continuously eligible since June 2004,
2. Were required to pay a premium under R9-31-1402(B)
for the month of July 2004,
3. Were required to pay any premium under R9-31-1402 for
the month of August 2004, and
4. As of August 31, 2004, had not paid the premiums

Historical Note
New Section made by exempt rulemaking at 8 A.A.R.
5007, effective January 1, 2003 (Supp. 02-4). Amended
by exempt rulemaking at 10 A.A.R. 3895, effective
August 30, 2004 (Supp. 04-3). Amended by exempt
rulemaking at 10 A.A.R. 4268, effective October 1, 2004
(Supp. 04-3). Amended by exempt rulemaking at 11
A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

R9-31-1419. Premium Payment During the Appeal and
Request for Hearing Process
A. Discontinuance of eligibility. To receive coverage from the
time an appeal and request for hearing is filed for a discontinu-
ance of eligibility until a Director’s decision is made.
1. A member shall:
   a. File an appeal and request for hearing prior to the
effective date of the discontinuance.
   b. Submit the full monthly premium amount to the
      Administration prior to the date of the discontinu-
      ance, and
   c. Continue to pay the full monthly premium amount
each month during the hearing process.
2. Failure of the member to pay the full premium shall result in
   the loss of eligibility effective the first of the next
   month.
3. If the decision is upheld, the Administration shall not
   refund any premium amounts that have been paid during
   the hearing process.
B. Increase in premium amount. To stop the Administration from
increasing the premium amount from the time an appeal and
request for hearing is filed until a Director’s decision is made.
1. A member shall file an appeal and request for hearing prior to the
effective date of the action. The member shall
   pay the lower premium amount until the decision is
   made.
2. If the decision to increase the premium is upheld, the
   member shall be responsible for paying the higher pre-
mium retroactively from the proposed effective date of
   the increase in the premium amount that is being appealed.
C. Imposition of a premium. To receive coverage from the time an appeal and request for hearing is filed for an imposition of a premium until a Director’s decision is made.
1. A member shall file an appeal and request for hearing in accordance with the time-frame as specified in R9-34-107.
2. A member shall pay the premium as billed by the Administration.
3. If the decision determines the imposition of the premium is incorrect then the premium will be refunded to the member.

D. Method of payment. To continue coverage a member shall pay the premium by:
1. Cashier’s check,
2. Money order, or
3. Other form approved by the Administration.

Historical Note

R9-31-1420. Payment of a Premium
When a member was discontinued with an unpaid premium, the parent or other responsible person shall pay the past due premium amounts for a child to the Administration or the child will remain ineligible for 90 days before the person can attain eligibility again.

Historical Note

ARTICLE 15. RESERVED

ARTICLE 16. SERVICES FOR AMERICAN INDIANS

R9-31-1601. General Requirements
A. An American Indian who is a member may receive:
1. Covered acute care services specified in this Chapter from:
   a. Indian Health Service (IHS) under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982,
   c. A contractor under A.R.S. § 36-2901, or
   d. An AHCCCS registered provider.
2. Covered behavioral health care services as specified in this Chapter from:
   a. IHS under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
   b. A Tribal Facility under A.R.S. § 36-2982, or
   c. A RBHA or TRBHA.
B. IHS, a Tribal facility, or a referred provider shall meet the requirements in this Chapter and A.A.C. Chapter 22, Articles 2 and 7 to receive reimbursement for AHCCCS-covered services. Title 9 A.A.C. 22, Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to an American Indian member under the KidsCare program, except that the term “IHS,” “Tribal facility,” or “referred provider” is substituted for “provider.”

Historical Note

R9-31-1602. Repealed

Historical Note

R9-31-1603. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1604. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Subsection labeling in subsection (A) amended to correct manifest typographical error (Supp. 01-3). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1605. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1606. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1607. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1608. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).
Title 9, Ch. 31  Arizona Administrative Code

Arizona Health Care Cost Containment System – Children’s Health Insurance Program

R9-31-1609. Repealed

Historical Note

R9-31-1610. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1611. Repealed

Historical Note

R9-31-1612. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1613. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1614. Repealed

Historical Note

R9-31-1615. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1616. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 10 A.A.R. 4660, effective January 1, 2005 (04-4). Amended by final rulemaking at 11 A.A.R. 3854, effective November 12, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

R9-31-1617. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 2365, effective May 9, 2002 (Supp. 02-2). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

R9-31-1618. Repealed

Historical Note

R9-31-1619. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 3171, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

R9-31-1620. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 11 A.A.R. 3246, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).

R9-31-1621. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 13 A.A.R. 671, effective April 7, 2007 (Supp. 07-1).
Arizona Administrative Code
Title 9, Ch. 31
Arizona Health Care Cost Containment System – Children’s Health Insurance Program

R9-31-1622. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1623. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1624. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

R9-31-1625. Repealed

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1998, Ch. 4, § 11, 4th Special Session, effective October 23, 1998 (Supp. 98-4). Amended by final rulemaking at 7 A.A.R. 5846, effective December 7, 2001 (Supp. 01-4). Section repealed by final rulemaking at 17 A.A.R. 1681, effective August 2, 2011 (Supp. 11-3).

ARTICLE 17. REPEALED

Article 17, consisting of Sections R9-31-1701 through R9-31-1713 and Sections R9-31-1716 through R9-31-1732, repealed by final rulemaking at 20 A.A.R. 248, effective January 7, 2014 (Supp. 14-1).

Article 17, consisting of Sections R9-31-1701 through R9-31-1724, made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4).

R9-31-1701. Repealed

Historical Note

R9-31-1702. Repealed

Historical Note

R9-31-1703. Repealed

Historical Note

R9-31-1704. Repealed

Historical Note

R9-31-1705. Repealed

Historical Note

R9-31-1706. Repealed

Historical Note

R9-31-1707. Repealed

Historical Note

R9-31-1708. Repealed

Historical Note

R9-31-1709. Repealed

Historical Note

R9-31-1710. Repealed

Historical Note

R9-31-1711. Repealed

Historical Note
R9-31-1712. Repealed

Historical Note

R9-31-1713. Repealed

Historical Note

R9-31-1714. Repealed

Historical Note
New Section made by exempt rulemaking at 8 A.A.R. 5007, effective January 1, 2003 (Supp. 02-4). Section repealed by exempt rulemaking at 11 A.A.R. 477, effective January 1, 2005 (Supp. 04-4).

R9-31-1715. Repealed

Historical Note

R9-31-1716. Repealed

Historical Note

R9-31-1717. Repealed

Historical Note

R9-31-1718. Repealed

Historical Note

R9-31-1719. Repealed

Historical Note

R9-31-1720. Repealed

Historical Note

R9-31-1721. Repealed

Historical Note

R9-31-1722. Repealed

Historical Note

R9-31-1723. Repealed

Historical Note

R9-31-1724. Repealed

Historical Note

R9-31-1725. Repealed

Historical Note

R9-31-1726. Repealed

Historical Note

R9-31-1727. Repealed

Historical Note

R9-31-1728. Repealed

Historical Note
R9-31-1729. Repealed

Historical Note

R9-31-1730. Repealed

Historical Note

R9-31-1731. Repealed

Historical Note

R9-31-1732. Repealed

Historical Note

R9-31-1733. Repealed

Historical Note

R9-31-1734. Repealed

Historical Note

R9-31-1735. Repealed

Historical Note
A. The director has full operational authority to adopt rules or to use the appropriate rules adopted for article 1 of this chapter to implement this article, including any of the following:

1. Contract administration and oversight of contractors.

2. Development of a complete system of accounts and controls for the program, including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably, including inpatient behavioral health services provided in a hospital.

3. Establishment of peer review and utilization review functions for all contractors.

4. Development and management of a contractor payment system.

5. Establishment and management of a comprehensive system for assuring quality of care.

6. Establishment and management of a system to prevent fraud by members, contractors and health care providers.

7. Development of an outreach program. The administration shall coordinate with public and private entities to provide outreach services for children under this article. Priority shall be given to those families who are moving off welfare. Outreach activities shall include strategies to inform communities, including tribal communities, about the program, ensure a wide distribution of applications and provide training for other entities to assist with the application process.

8. Coordination of benefits provided under this article for any member. The director may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The director may require members to assign to the administration rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies. The state has a right of subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this paragraph are controlling over the provisions of any insurance policy that provides benefits to a member if the policy is inconsistent with this paragraph.

9. Development and management of an eligibility, enrollment and redetermination system including a process for quality control.

10. Establishment and maintenance of an encounter claims system that ensures that ninety percent of the clean claims are paid within thirty days after receipt and ninety-nine percent of the remaining clean claims are paid within ninety days after receipt by the administration or contractor unless an alternative payment schedule is agreed to by the contractor and the provider. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.

11. Establishment of standards for the coordination of medical care and member transfers.

12. Requiring contractors to submit encounter data in a form specified by the director.

13. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

B. Notwithstanding any other law, if Congress amends title XXI of the social security act and the administration is required to make conforming changes to rules adopted pursuant to this article, the administration shall request a hearing with the joint health committee of reference for review of the proposed rule changes.

C. The director may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

D. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administration and that these records be maintained by the contractor for five years. The director shall also require that these records are available by a contractor on request of the secretary of the United States department of health and human services.
E. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which this information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall be designed to provide for the exchange of necessary information for the purposes of eligibility determination under this article. Notwithstanding any other law, a member's medical record shall be released without the member's consent in situations of suspected cases of fraud or abuse relating to the system to an officer of this state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

F. The director shall provide for the transition of members between contractors and noncontracting providers and the transfer of members who have been determined eligible from hospitals that do not have contracts to care for these persons.

G. To the extent that services are furnished pursuant to this article, a contractor is not subject to title 20 unless the contractor is a qualifying plan and has elected to provide services pursuant to this article.

H. As a condition of a contract, the director shall require contract terms that are necessary to ensure adequate performance by the contractor. Contract provisions required by the director include the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors who have posted other security, equal to or greater than that required by the administration, with a state agency for the performance of health service contracts if monies would be available from that security for the system on default by the contractor.

I. The director shall establish solvency requirements in contract that may include withholding or forfeiture of payments to be made to a contractor by the administration for the failure of the contractor to comply with a provision of the contract with the administration. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and to accomplish the orderly transition of members to other contractors or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor providing an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

J. For the sole purpose of matters concerning and directly related to this article, the administration is exempt from section 41-192.

K. The director may withhold payments to a noncontracting provider if the noncontracting provider does not comply with this article or adopted rules that relate to the specific services rendered and billed to the administration.

L. The director shall:

1. Prescribe uniform forms to be used by all contractors and furnish uniform forms and procedures, including methods of identification of members. The rules shall include requirements that an applicant personally complete or assist in the completion of eligibility application forms, except in situations in which the person has a disability.

2. By rule, establish a grievance and appeal procedure that conforms with the process and the time frames specified in article 1 of this chapter. If the program is suspended pursuant to section 36-2985, an applicant or member is not entitled to contest the denial, suspension or termination of eligibility for the program.

3. Apply for and accept federal monies available under title XXI of the social security act. Available state monies appropriated to the administration for the operation of the program shall be used as matching monies to secure federal monies pursuant to this subsection.

M. The administration is entitled to all rights provided to the administration for liens and release of claims as specified in sections 36-2915 and 36-2916 and shall coordinate benefits pursuant to section 36-2903, subsection F and be a payor of last resort for persons who are eligible pursuant to this article.

N. The director shall follow the same procedures for review committees, immunity and confidentiality that are prescribed in article 1 of this chapter.
A. The children's health insurance program is established for children who are eligible pursuant to section 36-2981, paragraph 6. The administration shall administer the program. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906, by a qualifying plan or by either tribal facilities or the Indian health service for Native Americans who are eligible for the program and who elect to receive services through the Indian health service or a tribal facility.

B. This article does not create a legal entitlement for any applicant or member who is eligible for the program.

C. The director shall take all steps necessary to implement the administrative structure for the program and to begin delivering services to persons within sixty days after approval of the state plan by the United States department of health and human services.

D. The administration shall perform eligibility determinations for persons applying for eligibility and annual redeterminations for continued eligibility pursuant to this article.

E. The administration shall adopt rules for the collection of copayments from members whose income does not exceed one hundred fifty percent of the federal poverty level and for the collection of copayments and premiums from members whose income exceeds one hundred fifty percent of the federal poverty level. The director shall adopt rules for disenrolling a member if the member does not pay the premium required pursuant to this section. The director shall adopt rules to prescribe the circumstances under which the administration shall grant a hardship exemption to the disenrollment requirements of this subsection for a member who is no longer able to pay the premium.

F. Before enrollment, a member, or if the member is a minor, that member's parent or legal guardian, shall select an available health plan in the member's geographic service area or a qualifying health plan offered in the county, and may select a primary care physician or primary care practitioner from among the available physicians and practitioners participating with the contractor in which the member is enrolled. The contractors shall only reimburse costs of services or related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled, except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.

G. Eligibility for the program is creditable coverage as defined in section 20-1379.

H. Notwithstanding section 36-2983, the administration may purchase for a member employer-sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the centers for medicare and medicaid services. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Title 9, Chapter 22

Amend: R9-22-712.35, R9-22-712.61, R9-22-712.71
GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - REGULAR RULEMAKING

MEETING DATE: September 7, 2022

TO: Members of the Governor’s Regulatory Review Council (Council)

FROM: Council Staff

DATE: August 12, 2022

SUBJECT: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Title 9, Chapter 22

Amend: R9-22-712.35, R9-22-712.61, R9-22-712.71

Summary:

This regular rulemaking from the Arizona Health Care Cost Containment System (AHCCCS) seeks to amend three (3) rules in Title 9, Chapter 22, Article 7 related to Standards for Payment. Specifically, AHCCCS indicates this proposed rulemaking will amend and clarify rules specifying requirements for receipt of Differential Adjusted Payment (DAP) for qualifying hospitals for both inpatient and outpatient services for the time period of October 1, 2022 through September 30, 2023. AHCCCS indicates the proposed rulemaking will authorize AHCCCS to continue rewarding innovative activities and broaden the reach of the present model, emphasizing improved patient care and reduced growth in the cost of care.

AHCCCS indicates DAP initiatives are strategically designed to reward quality outcomes and reduce growth in the cost of health care. The objective of DAP is to reward hospital providers that have taken designated actions to improve patients’ care experience, improve members’ health, and reduce the growth of the cost of care. Hospitals which satisfy the requirements delineated in rule will receive increased payments from the AHCCCS Administration and Contractors for inpatient and outpatient services. AHCCCs indicates the
The proposed rules represent its expanding efforts to enhance accountability of the health care delivery system.

1. **Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?**

   AHCCCS cites both general and specific statutory authority for these rules.

2. **Do the rules establish a new fee or contain a fee increase?**

   This rulemaking does not establish a new fee or contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   AHCCCS indicates it did not review or rely on any study in conducting this rulemaking.

4. **Summary of the agency’s economic impact analysis:**

   AHCCCS anticipates that the DAP rulemaking will result in approximately $155 million of additional payments for the contract year October 1, 2022 through September 30, 2023 to 135 hospitals. AHCCCS, taxpayers, and providers will directly benefit from this rulemaking as the DAP payments incentivize improved patient care, innovation, efficient delivery of services, and the reduction in the growth of the costs of healthcare.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   AHCCCS did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State’s fiduciary responsibility to Arizona taxpayers.

6. **What are the economic impacts on stakeholders?**

   The State, taxpayers, and providers will directly benefit from this rulemaking as the payment model will reward efficient utilization of services. Hospital providers which participate in the health information exchange will benefit by receiving a higher rate of reimbursement for medical services. In addition, patients are expected to experience improved care while the State and taxpayers will be positively affected by the more efficient delivery of health care services and the reduced growth in the cost of care.
7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

AHCCCS indicates there were no changes to the rules between the Notice of Proposed Rulemaking published in the Administrative Register and the Notice of Final Rulemaking now before the Council.

8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

AHCCCS indicates it did not receive public or stakeholder comments related to this rulemaking.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. AHCCCS indicates that the rules do not require a permit, license, or agency authorization.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates that the rules are not more stringent than corresponding federal law.

11. **Conclusion**

AHCCCS seeks to amend three (3) rules in Title 9, Chapter 22, Article 7 related to Standards for Payment. Specifically, AHCCCS indicates this proposed rulemaking will amend and clarify rules specifying requirements for receipt of Differential Adjusted Payment (DAP) for qualifying hospitals for both inpatient and outpatient services for the time period of October 1, 2022 through September 30, 2023.

AHCCCS is requesting an immediate effective date for this rulemaking pursuant to A.R.S. § 41-1032. Specifically, AHCCCS indicates that this rulemaking provides a benefit to the public and a penalty is not associated with a violation of the rule. See A.R.S. § 41-1032(A)(4).

Council staff believes AHCCCS has provided adequate justification for an immediate effective date for the rules. Council staff recommends approval of this rulemaking.
July 19, 2022

VIA EMAIL: grrc@azdoa.gov

Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007


Dear Ms. Sornsin:

1. The close of record date: 7/5/2022
2. Does the rulemaking activity relate to a Five Year Review Report: No
   a. If yes, the date the Council approved the Five Year Review Report: N/A
3. Does the rule establish a new fee: No
   a. If yes, what statute authorizes the fee: N/A
4. Does the rule contain a fee increase: No
5. Is an immediate effective date requested pursuant to A.R.S. 41-1032: Yes

AHCCCS certifies that the preamble discloses a reference to any study relevant to the rule that the agency reviewed. AHCCCS certifies that the preamble states that it did not rely on any such study in the agency’s evaluation of or justification for the rule.

AHCCCS certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.
The following documents are enclosed:

1. Notice of Final Rulemaking, including the preamble, table of contents, and text of each rule;
2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;
3. If applicable: The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript or minutes;
4. If applicable: Any analysis submitted to the agency regarding the rule’s impact on the competitiveness of businesses in this state as compared to the competitiveness of business in other states;
5. If applicable: Material incorporated by reference;
6. General and specific statutes authorizing the rules, including relevant statutory definitions; and
7. If applicable: If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition.

Sincerely,

Kasey Rogg

Kasey Rogg
Assistant Director

Attachments
NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:
   R9-22-712.35 Amend
   R9-22-712.61 Amend
   R9-22-712.71 Amend

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):
   Authorizing statute: A.R.S. § 36-2903.01(A)
   Implementing statute: A.R.S. § 36-2903.01(G)(12)

3. The effective date of the rule:
   As specified in A.R.S. § 41-1032(A)(4), the agency requests an immediate effective date to provide a benefit to the public and a penalty is not associated with a violation of the rule.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:
5. **The agency’s contact person who can answer questions about the rulemaking:**

Name: Nicole Fries  
Address: AHCCCS  
Office of Administrative Legal Services  
701 E. Jefferson, Mail Drop 6200  
Phoenix, AZ 85034  
Telephone: (602) 417-4232  
Fax: (602) 253-9115  
E-mail: AHCCCSRules@azahcccs.gov  
Web site: www.azahcccs.gov

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

AHCCCS Differential Adjusted Payment (DAP) initiatives are strategically designed to reward quality outcomes and reduce growth in the cost of health care. The objective of DAP delineated in this proposed rulemaking is to reward hospital providers that have taken designated actions to improve patients’ care experience, improve members’ health, and reduce the growth of the cost of care. Hospitals which satisfy the requirements delineated in rule will receive increased payments from the AHCCCS Administration and Contractors for inpatient and outpatient services. The proposed DAP rules represent the AHCCCS Administration’s expanding efforts to enhance accountability of the health care delivery system. The proposed rulemaking will amend and clarify rules specifying requirements for receipt of DAP for qualifying hospitals for both inpatient and outpatient services for the time period of October 1, 2022 through September 30, 2023. The proposed rulemaking will
authorize AHCCCS to continue rewarding innovative activities and broaden the reach of the present model, emphasizing improved patient care and reduced growth in the cost of care.

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

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

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

   Not applicable.

9. **A summary of the economic, small business, and consumer impact:**

   The Administration anticipates that the DAP rulemaking will result in approximately $155 million of additional payments for the contract year October 1, 2022 through September 30, 2023 to 135 hospitals.

10. **A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:**

    There were no changes made between the proposed and final rulemakings.
11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

There were no public comments made regarding this rulemaking.

12. 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:

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

Not applicable.

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

Not applicable.

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

Not applicable.
13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:
ARTICLE 7. STANDARDS FOR PAYMENTS

Sections

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.61. DRG Payments: Exceptions

R9-22-712.71. Final DRG Payment
ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;

2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;

5. By 113 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or

6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).

E. For outpatient services with dates of service from October 1, 2022 through September 30, 2023, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration’s public website as part of its fee schedule subsequent to the
A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in a, b, c or d:
   a. By April 1, 2024\text{,}2022, the hospital must have submitted a Letter of Intent (LOI) to AHCCCS\text{ and }the Health Information Exchange (HIE) in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
      i. No later than April 1, 2024\text{,}2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS\text{ and }the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
      ii. No later than May 1, 2024\text{,}2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
         (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.
         (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
(3)  Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
vii. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.

vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 to October 2021 data, to the final data quality profile, based on March 2022 data.

2. Meet a minimum performance standard of at least 60% based on March 2022 data.

3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria,
regardless of the percentage improvement from the baseline measurements.

**DAP HIE Data Quality Standards CYE 2022-2023 Measure Categories:**

Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.5% if criteria are met for all categories.

1. Data source and data site information must be submitted on all ADT transactions. (0.5%)
2. Event type must be properly coded on all ADT transactions. (0.5%)
3. Patient class must be properly coded on all appropriate ADT transactions. (0.5%)
4. Patient demographic information must be submitted on all ADT transactions. (0.5%)
5. Race must be submitted on all ADT transactions. (0.5%)
6. Ethnicity must be submitted on all ADT transactions. (0.5%)
7. Diagnosis must be submitted on all ADT transactions. (0.5%)
8. Overall completeness of the ADT message. (0.5%)

**b.** By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates:

1. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.
2. No later than April 1, 2022:
For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

b. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable).

By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital
shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use,

ii. Number of ICU beds available for use,

iii. Number of Medical-Surgical beds in use,

iv. Number of Medical-Surgical beds available for use,

v. Number of Telemetry beds in use,

vi. Number of Telemetry beds available for use.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria specified in a, b, c or b:

a. In order to qualify, By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE
organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new
prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, January 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2022 data.
(2) Meet a minimum performance standard of at least 60% based on March 2022 data.

(3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

DAP HIE Data Quality Standards CYE 2022 Data Quality Measures:

- Measure Categories:
- Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0% DAP increase for each category of the five measure categories, for a total potential increase of 10.0% if criteria are met for all categories indicating a DAP.

(1) Data source and data site information must be submitted on all ADT transactions. (21.0%)

(2) Event type must be properly coded on all ADT transactions. (21.0%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (20.0%)

(4) Patient demographic information must be submitted on all ADT transactions. (20.0%)

(5) Race must be submitted on all ADT transactions. (2.0%)

(6) Ethnicity must be submitted on all ADT transactions. (2.0%)

(7) Diagnosis must be submitted on all ADT transactions. (2.0%)

(8) Overall completeness of the ADT message. (20.0%)

By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral
Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates:

i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:
   (1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
   (2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
   (3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

bc. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable).
By April 30, 2022, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.
d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use

ii. Number of ICU beds available for use

iii. Number of Medical-Surgical beds in use

iv. Number of Medical-Surgical beds available for use

v. Number of Telemetry beds in use

vi. Number of Telemetry beds available for use

3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in a, b, c, d, e, or f:

a. In order to qualify, by April 1, 2022, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19
related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the
provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to either a SDOH Closed-Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization or an Advance Directives Registry platform operated by the qualifying HIE organization.

vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to DAP increases described below: in 3.a.x.
Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 October 2021 data, to the final data quality profile, based on March 2022 data.

Meet a minimum performance standard of at least 60% based on March 2022 data.

If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

DAP HIE Data Quality Standards CYE 2022 Measure Categories:

Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.50% if criteria are met for all categories.

(1) Data source and data site information must be submitted on all ADT transactions. (0.5%)

(2) Event type must be properly coded on all ADT transactions. (0.5%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5%)

(5) Race must be submitted on all ADT transactions. (0.5%)

(6) Ethnicity must be submitted on all ADT transactions. (0.5%)

(7) Diagnosis must be submitted on all ADT transactions. (0.5%)
b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;

i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:

(1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date.
through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

b. On March 15, 2022 is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website; APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.

c. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website for long-term care hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

d. On March 15, 2022 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website for rehabilitation hospitals. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

e. By April 30, 2022, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

4. A hospital designated as type: hospital, subtype: long term or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the following criteria. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically,
the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use

ii. Number of ICU beds available for use

iii. Number of Medical-Surgical beds in use

iv. Number of Medical-Surgical beds available for use

v. Number of Telemetry beds in use

vi. Number of Telemetry beds available for use

45. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets these criteria specified in a or b;

a. By April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital's go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

iv. No later than June 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include,
at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2021, the deadline for this milestone will be November 1, 2022.

v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

vii. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on October 2021 data, to the final data quality profile, based on March 2022 data.
2. Meet a minimum performance standard of at least 60% based on March 2022 data.

3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

ix. DAP HIE Data Quality Standards CYE 2022 Measure Categories:

Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a DAP increase for select Data Quality Measures for a total of 2.5% if criteria are met for all categories indicating a DAP.

(1) Data source and data site information must be submitted on all ADT transactions. (0.5%)

(2) Event type must be properly coded on all ADT transactions. (0.5%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5%)

(5) Overall completeness of the ADT message. (0.5%)

b. By March 15, 2022, the facility must submit a LOI to enter into a CCA with a non-HIS/638 facility (a fully signed copy of a CCA with a non-HIS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a non-IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
The IHS/Tribal 638 facility will have in place a signed CCA with a non-IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

i. The IHS/Tribal 638 facility will have a valid referral template in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

ii. The IHS/Tribal 638 facility will continue to assume responsibility of the referred member, maintaining records and release of information protocol including clinical documentation of services provided by the non-IHS/Tribal 638 facility.

iii. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the IHS/Tribal 638 facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

iv. The IHS/638 facility will submit a minimum of one referral and any supporting medical documentation to the non-IHS/Tribal 638 facility by September 1, 2022. During CYE 2023, from October 1, 2022, through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA referrals per month to the non-IHS/Tribal 638 facility.

v. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA referrals to the non-IHS/Tribal 638 facility by March 15, 2022, and submit an average of 5 CCA referrals per month by May 31, 2022.

F. If a hospital submits a Letter of Intent to AHCCCS and received the Differential Adjusted Payments October 1, 2020 through September 30, 2021 but fails to achieve or maintain one or
more of the required criteria by the specified date, that hospital will be ineligible to receive any
Differential Adjusted Payments for dates of service from October 1, 2021 through September 30, 2022 if a Differential Adjusted Payment is available at that time.

G. Fee adjustments made under subsection (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS’ website.
R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype; rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;

2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

3. Hospitals designated as type: hospital, subtype; psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall
be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register.

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

F. For inpatient services with a date of admission from October 1, 2021 through September 30, 2022, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration’s public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in subsection a, b, c, or d:

a. By April 1, 2022, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

   (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the
external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.

vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in 1.a.x.

(1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2022 data.

(2) Meet a minimum performance standard of at least 60% based on March 2022 data.

(3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

DAP HIE Data Quality Standards CYE 2022 Measure Categories:
Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five measure categories, for a total potential increase of 2.5% if criteria are met for all categories.

(1) Data source and data site information must be submitted on all ADT transactions. (0.5%)
(2) Event type must be properly coded on all ADT transactions. (0.5%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5%)

(5) Race must be submitted on all ADT transactions. (0.5%)

(6) Ethnicity must be submitted on all ADT transactions. (0.5%)

(7) Diagnosis must be submitted on all ADT transactions. (0.5%)

(8) Overall completeness of the ADT message. (0.5%)

b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates:

i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:

(1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
(3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

bg. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use

ii. Number of ICU beds available for use

iii. Number of Medical-Surgical beds in use

iv. Number of Medical-Surgical beds available for use

v. Number of Telemetry beds in use

vi. Number of Telemetry beds available for use
2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsection a, b, c, or d:

a. In order to qualify, by April 1, 2022 the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

   (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated
CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vii viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in 2.x.x.

(1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 - October 2021 data, to the final data quality profile, based on March 2022 data.

(2) Meet a minimum performance standard of at least 60% based on March 2022 data.

(3) If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x xi. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0% DAP increase for each category of the five measure categories, for a total potential increase of 10.0% select Data
Quality Measures for a total of 8.0% if criteria are met for all categories indicating a DAP.

(1) Data source and data site information must be submitted on all ADT transactions. (2.0%)

(2) Event type must be properly coded on all ADT transactions. (2.0%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (2.0%)

(4) Patient demographic information must be submitted on all ADT transactions. (2.0%)

(5) Race must be submitted on all ADT transactions. (2.0%)

(6) Ethnicity must be submitted on all ADT transactions. (2.0%)

(7) Diagnosis must be submitted on all ADT transactions. (2.0%)

(58) Overall completeness of the ADT message. (2.0%)

b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.

i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:

(1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
(2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

b. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use
ii. Number of ICU beds available for use

iii. Number of Medical-Surgical beds in use

iv. Number of Medical-Surgical beds available for use

v. Number of Telemetry beds in use

vi. Number of Telemetry beds available for use
R9-22-712.71. Final DRG Payment

The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.

A. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

B. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

C. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration’s website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson Street, Phoenix, Arizona.

D. For inpatient services with a date of discharge from October 1, 2022 through September 30, 2023, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration’s public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2022. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in (4)(a)(i), (1) through (10) or (ii):
a. By April 1, 2022, a hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.

   i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

   ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

   (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

   (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.
vii. No later than November 1, 2022, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vii-viii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in x-xi.

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2020 - October 2021 data, to the final data quality profile, based on March 2022 data.

2. Meet a minimum performance standard of at least 60% based on March 2022 data.

3. If performance meets or exceeds an upper threshold of 90% based on March 2022 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5% DAP increase for each category of the five
measure categories, for a total potential increase of 2.50% if criteria are met for all categories.

(1) Data source and data site information must be submitted on all ADT transactions. (0.5%)

(2) Event type must be properly coded on all ADT transactions. (0.5%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5%)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5%)

(5) Race must be submitted on all ADT transactions. (0.5%)

(6) Ethnicity must be submitted on all ADT transactions. (0.5%)

(7) Diagnosis must be submitted on all ADT transactions. (0.5%)

(58) Overall completeness of the ADT message. (0.5%)

b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates.

i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:

(1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.
(2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

bç. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2022, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

d. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI) to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to the Arizona Department of Health Services (ADHS). Specifically, the hospital shall report the following through an ADHS approved method to ADHS weekly, with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use.
ii. Number of ICU beds available for use.

iii. Number of Medical-Surgical beds in use.

iv. Number of Medical-Surgical beds available for use.

v. Number of Telemetry beds in use.

vi. Number of Telemetry beds available for use.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in (4)(b)(i), (1) through (10) or (ii);

a. In order to qualify, by April 1, 2022, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2022, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2022, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

iv. No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
v. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform and usage of the Arizona Healthcare Directives Registry (AzHDR) operated by the qualifying HIE organization.

vii. No later than November 1, 2022, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

viii. No later than January 1, 2023, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. No later than May 1, 2023, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

x. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below in 2.a.x.

(1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July–October 2021 data, to the final data quality profile, based on March–April 2022 data.

(2) Meet a minimum performance standard of at least 60% based on March–May 2022 data.
If performance meets or exceeds an upper threshold of 90% based on March 2022 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0% DAP increase for each category of the five measure categories, select Data Quality Measures for a total potential increase of 10.0% if criteria are met for all categories indicating a DAP.

(1) Data source and data site information must be submitted on all ADT transactions. (±1.0%)

(2) Event type must be properly coded on all ADT transactions. (±1.0%)

(3) Patient class must be properly coded on all appropriate ADT transactions. (±0%)

(4) Patient demographic information must be submitted on all ADT transactions. (±0%)

(5) Race must be submitted on all ADT transactions. (±0%)

(6) Ethnicity must be submitted on all ADT transactions. (±0%)

(7) Diagnosis must be submitted on all ADT transactions. (±0%)

(8) Overall completeness of the ADT message. (±0%)

b. By April 1, 2022, the hospital must have submitted a registration form for participation in the Social Determinants of Health (SDOH) Closed-Loop Referral Platform operated by the qualifying HIE organization in which the parties agree to achieve the following milestones by the specified dates;
i. No later than April 1, 2022, submit registration form(s) for participation using the form(s) on the website of the qualifying HIE organization.

ii. No later than April 1, 2022:

(1) For hospitals with an active Participation Agreement with a qualifying HIE organization, submit a signed Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(2) For hospitals without an active Participation Agreement with a qualifying HIE organization, execute a Participation Agreement and a Participant SDOH Addendum to participate in the SDOH Closed-Loop Referral Platform.

(3) For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022.

iii. No later than September 30, 2022, or as soon as reasonably practicable thereafter as determined by the qualifying HIE organization, initiate use of the SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization. After go-live, the hospital must regularly utilize the SDOH Closed-Loop Referral Platform, which will be measured by facilitating at least 10 referrals on average per month from go-live date through the end of CYE 2023. All referrals entered into the system by the hospital will be counted towards volume requirements.

b. By March 15, 2022, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable).

By April 30, 2022, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services
provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2022.

v. The non-IHS/Tribal 638 facility will receive a minimum of one referral and any supporting medical documentation from the IHS/Tribal 638 facility and submit a minimum of one claim to AHCCCS under the CCA claiming guidelines, by September 1, 2022. During CYE 2023, from October 1, 2022 through September 30, 2023, demonstrate a concerted effort to submit an average of 5 CCA claims per month to AHCCCS.

vi. Existing facilities with a CCA established in CYE 2022 will actively submit a minimum of 5 CCA claims to AHCCCS by March 15, 2022, and submit an average of 5 CCA claims per month to AHCCCS by May 31, 2022.

D. Upon the declaration of the end of the State of Arizona Public Health Emergency (PHE) issued on March 11, 2020, the hospital must submit a letter of intent (LOI)
to AHCCCS in which it agrees to adult and pediatric bed capacity reporting to
the Arizona Department of Health Services (ADHS). Specifically, the hospital
shall report the following through an ADHS approved method to ADHS weekly,
with deadlines and format prescribed by ADHS:

i. Number of ICU beds in use

ii. Number of ICU beds available for use

iii. Number of Medical-Surgical beds in use

iv. Number of Medical-Surgical beds available for use

v. Number of Telemetry beds in use

vi. Number of Telemetry beds available for use
1. **Identification of rulemaking.**

AHCCCS Differential Adjusted Payment (DAP) initiatives are strategically designed to reward quality outcomes and reduce growth in the cost of health care. The objective of DAP delineated in this final rulemaking is to reward hospital providers that have taken designated actions to improve patients’ care experience, improve members’ health, and reduce the growth of the cost of care. Hospitals which satisfy the requirements delineated in rule will receive increased payments from the AHCCCS Administration and Contractors for inpatient and outpatient services. The DAP rules represent the AHCCCS Administration’s expanding efforts to enhance accountability of the health care delivery system. The final rulemaking will amend and clarify rules specifying requirements for receipt of DAP for qualifying hospitals for both inpatient and outpatient services for the time period of October 1, 2022 through September 30, 2023. The final rulemaking will authorize AHCCCS to continue rewarding innovative activities and broaden the reach of the present model, emphasizing improved patient care and reduced growth in the cost of care.

a. **The conduct and its frequency of occurrence that the rule is designed to change:**
The rule is designed to incentivize hospital participation in the state’s health information exchange (HIE) which are expected to enhance quality of care and reduced growth in the cost of care.

b. **The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:**

It is expected that the change in hospital behavior will improve patient care experience, improve patient health, and reduce the growth in the cost of health care.

c. **The estimated change in frequency of the targeted conduct expected from the rule change:**

It is anticipated that hospitals which participate in the health information exchange in order to receive increased payments through the DAP initiative will continue to do so going forward.

2. **Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.**

The State, taxpayers, and providers will directly benefit from this rulemaking as the payment model will reward efficient utilization of services. Hospital providers which participate in the health information exchange will benefit by receiving a higher rate of reimbursement for medical services. In addition, patients are expected to experience improved care while the State and taxpayers will be positively affected by the more efficient delivery of health care services and the reduced growth in the cost of care.
3. **Cost benefit analysis.**

a. **Probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking including the number of new full-time employees necessary to implement and enforce the proposed rule:**

i. **Cost:**

The Administration anticipates that the DAP rulemaking will result in approximately $155 million of additional payments for the contract year October 1, 2022 through September 30, 2023 to 135 hospitals.

ii. **Benefit:**

The AHCCCS Administration, taxpayers, and providers will directly benefit from this rulemaking as the DAP payments incentivize improved patient care, innovation, efficient delivery of services, and the reduction in the growth of the costs of health care.

iii. **Need for additional Full-time Employees:**

The Administration does not anticipate the need to hire full-time employees as a result of this rulemaking.

b. **Probable costs and benefits to political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.**

This rulemaking does not directly affect political subdivisions.
4. **General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.**

The Administration anticipates no economic impact on public and private employment.

5. **Statement of probable impact of the proposed rule on small businesses.** The statement shall include:

   a. **Identification of the small businesses subject to the proposed rulemaking.**

      Of the 135 hospitals, 2 hospitals satisfy the definition of small businesses.

   b. **Administrative and other costs required for compliance with the proposed rulemaking.**

      The Administration does not anticipate an impact on the small business community because providers do not incur additional costs for participating in the state’s health information exchange.

   c. **Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency’s decision to use or not use each method:**

      i. **Establishing less stringent compliance or reporting requirements in the rule for small businesses:**
This rulemaking does not impose compliance or reporting requirements on small businesses. Participation in the state’s health information exchange is voluntary and will result in increased funding for medical services under this rule.

ii. **Establishing less stringent schedules deadlines in the rule for compliance or reporting requirements for small businesses:**

This rulemaking does not impose compliance or reporting requirements on small businesses. Participation in the state’s health information exchange are voluntary and will result in increased funding for medical services under this rule.

iii. **Consolidate or simplify the rule’s compliance or reporting requirements for small businesses:**

This rulemaking does not impose compliance or reporting requirements on small businesses. Participation in the state’s health information exchange are voluntary and will result in increased funding for medical services under this rule.

iv. **Establish performance standards for small businesses to replace design or operational standards in the rule; and**

This rulemaking does not establish performance standards for small businesses.

v. **Exempting small businesses from any or all requirements of the rule.**

Exempting small businesses is not applicable to this rulemaking.
d. **The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

It is anticipated that private persons and consumers of medical services provided by hospitals will benefit from an improved patient care experience, improved health outcomes, and a reduction in the growth of medical care costs.

6. **Statement of the probable effect on state revenues.**

It is anticipated that the rulemaking will not affect state revenues.

7. **Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**

The Administration did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State’s fiduciary responsibility to Arizona taxpayers.

8. **A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data.**

The Administration did not rely on any data for this rulemaking.
CMS Medicare Outpatient Rural Cost-to-Charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the Federal Register on or before August 1st of that year.

D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.

E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

**Historical Note**


**R9-22-712.31. Reserved**

**R9-22-712.32. Reserved**

**R9-22-712.33. Reserved**

**R9-22-712.34. Reserved**

**R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees**

A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:

1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
4. By 65 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria specified below for the applicable hospital subtype.
5. By 115 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.

B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:

1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.

C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.

D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).

E. For outpatient services with dates of service from October 1, 2021 through September 30, 2022, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration’s public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2021. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in subsection (E)(1)(a), or (b):
   a. By April 1, 2021, the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE) in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.
      i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
      ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the
hospital must complete the following COVID-19 related milestones, if they are applicable:

1. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

2. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

3. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2021, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2021, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.

2. Meet a minimum performance standard of at least 60 percent based on March 2021 data.

3. If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5 percent DAP increase for each category of the five measure categories, for a total potential increase of 2.5 percent if criteria are met for all categories.

1. Data source and data site information must be submitted on all ADT transactions. (0.5 percent)

2. Event type must be properly coded on all ADT transactions. (0.5 percent)

3. Patient class must be properly coded on all appropriate ADT transactions. (0.5 percent)

4. Patient demographic information must be submitted on all ADT transactions. (0.5 percent)

5. Overall completeness of the ADT message. (0.5 percent)

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for
an increase if it meets the criteria specified in subsection (2)(a) or (b):

a. In order to qualify, by April 1, 2021, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
   i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.
   ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
      (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
      (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
      (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
   iii. No later than May 1, 2021, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
   iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
   v. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
   vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform operated by the qualifying HIE organization.
   vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
   viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
   ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below.
      (1) Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.
      (2) Meet a minimum performance standard of at least 60 percent based on March 2021 data.
      (3) If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.
   x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0 percent DAP increase for each category of the five measure categories, for a total potential increase of 10.0 percent if criteria are met for all categories.
      (1) Data source and data site information must be submitted on all ADT transactions. (2.0 percent)
      (2) Event type must be properly coded on all ADT transactions. (2.0 percent)
      (3) Patient class must be properly coded on all appropriate ADT transactions. (2.0 percent)
      (4) Patient demographic information must be submitted on all ADT transactions. (2.0 percent)
      (5) Overall completeness of the ADT message. (2.0 percent)

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
   i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have
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3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in subsections (3)(a), (b), (c), (d), (e), or (f):
   a. In order to qualify, by April 1, 2021, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:
      i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved:
         (1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
         (2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
         (3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
      ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
         (1) Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.
         (2) Meet a minimum performance standard of at least 60 percent based on March 2021 data.
         (3) If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data, the hospital must meet the criteria, regardless of the percentage improvement from the baseline measurements.
   iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.
   v. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.
   vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to either a SDOH Closed-Loop Referral Platform operated by the qualifying HIE organization or an Advance Directives Registry platform operated by the qualifying HIE organization.
   vii. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
   viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.
   ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to DAP increases described in subsection (3).
         (1) Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on March 2021 data.
         (2) Meet a minimum performance standard of at least 60 percent based on March 2021 data.
         (3) If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data, the hospital must meet the criteria, regardless of the percentage improvement from the baseline measurements.
   x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this
notice, qualify for a 0.5 percent DAP increase for each category of the five measure categories, for a total potential increase of 2.5 percent if criteria are met for all categories.

1. Data source and data site information must be submitted on all ADT transactions. (0.5 percent)
2. Event type must be properly coded on all ADT transactions. (0.5 percent)
3. Patient class must be properly coded on all appropriate ADT transactions. (0.5 percent)
4. Patient demographic information must be submitted on all ADT transactions. (0.5 percent)
5. Overall completeness of the ADT message. (0.5 percent)

b. On March 15, 2021, is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website;

c. On March 15, 2021, meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website.

d. On March 15, 2021, meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Provider Data Catalog website.

e. By April 30, 2021, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:
   i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.
   ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.
   iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.
   iv. AHCCCS will monitor activity specified under the CCA or CCAAs to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (IHS) or under Tribal authority will qualify for an increase if it meets the criteria specified in subsections (4)(a) or (b);

a. By April 1, 2021, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved:
   i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:
   i. Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
   ii. Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.
   iii. Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iv. No later than June 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2021, the deadline for this milestone will be November 1, 2021.

v. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improve-
ment effort, as defined by the qualifying HIE organization.

vi. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

vii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

b. By April 30, 2021, the facility must have entered into a CCA with a non-IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in a signed CCA with a non-IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

i. The IHS/Tribal 638 facility will have a valid referral template in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

ii. The IHS/Tribal 638 facility will continue to assume responsibility of the referred member, maintaining records and release of information protocol including clinical documentation of services provided by the non-IHS/Tribal 638 facility.

iii. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the IHS/Tribal 638 facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

F. If a hospital submits a Letter of Intent to AHCCCS and received the Differential Adjusted Payments October 1, 2020 through September 30, 2021 but fails to achieve or maintain one or more of the required criteria by the specified date, that hospital will be ineligible to receive any Differential Adjusted Payments for dates of service from October 1, 2021 through September 30, 2022 if a Differential Adjusted Payment is available at that time.

G. Fee adjustments made under subsections (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are available at that time.

Historical Note

New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 13 A.A.R. 3584, effective October 1, 2007 (Supp. 07-4). Amended by final rulemaking at 14 A.A.R. 1439, effective May 31, 2008 (Supp. 08-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4).

R9-22-712.36. Reserved

R9-22-712.37. Reserved

R9-22-712.38. Reserved

R9-22-712.39. Reserved

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.

B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.

C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:

1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or

2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.

D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.

E. Rebase. AHCCCS shall rebase the outpatient fees every five years.

F. Statewide CCR:

1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.

2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).

G. Other Updates. In addition to the other updates provided for in this Section, the Administration may adjust the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION


R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding Section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype: rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;

2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

3. Hospitals designated as type: hospital, subtype: psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

B. Notwithstanding Section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this Section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding Section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding Section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the Federal Register.

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

F. For inpatient services with a date of admission from October 1, 2021, through September 30, 2022, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration’s public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2021. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in subsections (1)(a), or (b):

a. By April 1, 2021, the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.

i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2021, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new
prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2021, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

(1) Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.

(2) Meet a minimum performance standard of at least 60 percent based on March 2021 data.

(3) If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. By May 1, 2021, the hospital must complete the Phase I final data quality profile with a qualifying HIE organization;

(1) Data source and data site information must be submitted on all ADT transactions. (0.5 percent)

(2) Event type must be properly coded on all ADT transactions. (0.5 percent)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5 percent)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5 percent)

(5) Overall completeness of the ADT message. (0.5 percent)

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsections (2)(a), or (b):

a. In order to qualify, by April 1, 2021, the hospital must have submitted a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2021, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.
iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.

2. Meet a minimum performance standard of at least 60 percent based on March 2021 data.

3. If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0 percent DAP increase for each category of the five measure categories, for a total potential increase of 10.0 percent if criteria are met for all categories.

1. Data source and data site information must be submitted on all ADT transactions. (2.0 percent)

2. Event type must be properly coded on all ADT transactions. (2.0 percent)

3. Patient class must be properly coded on all appropriate ADT transactions. (2.0 percent)

4. Patient demographic information must be submitted on all ADT transactions. (2.0 percent)

5. Overall completeness of the ADT message. (2.0 percent)

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with an IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4). Amended by final rulemaking at 23 A.A.R. 2338, effective October 1, 2017 (Supp. 17-3). Amended by final rulemaking at 24 A.A.R. 2851, effective October 1, 2018 (Supp. 18-3). Amended by final rulemaking at 25 A.A.R. 3111 and at 25 A.A.R. 3114, effective October 1, 2019 (Supp. 19-4). Amended by final rulemaking at 26 A.A.R. 3025, with an immediate effective date of November 3, 2020 (Supp 20-4). AHCCCS filed an incorrect version of a final rulemaking which made amendments to this Section published at 27 A.A.R. 2501 (October 29, 2021); AHCCCS filed the correct version of its final rulemaking on December 3, 2021, with this Section amended by final rulemaking at 27 A.A.R. 3015 (December 31, 2021), effective October 1, 2021 (Supp. 21-4).

R9-22-712.62. DRG Base Payment
A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjustments.

B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital’s labor-related share of that amount is adjusted by the hospital’s wage index. The hospital’s labor share is determined based on the labor share for the Medicare inpatient prospective payment system published in 85 Fed. Reg. 59060 through 59061 (September 18, 2020). The hospital’s wage index is determined based on the wage index
R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members

In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.

1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.

2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.

3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.

4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

R9-22-712.71. Final DRG Payment

A. The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.

B. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

C. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.

D. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration’s website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson Street, Phoenix, Arizona.

E. For inpatient services with a date of discharge from October 1, 2021, through September 30, 2022, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration’s public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2021. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in subsections (1)(a) or (b):

a. By April 1, 2021, a hospital the hospital must have submitted a Letter of Intent (LOI) to AHCCCS and the Health Information Exchange (HIE), in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.

i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDC-recognized code sets to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.

iii. No later than May 1, 2021, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf.

iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries.
that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2021, the hospital must approve and authorize a formal statement of work (SOW) to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a Social Determinants of Health (SDOH) Closed Loop Referral Platform operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

(1) Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.

(2) Meet a minimum performance standard of at least 60 percent based on March 2021 data.

(3) If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data, the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 0.5 percent DAP increase for each category of the five measure categories, for a total potential increase of 2.5 percent if criteria are met for all categories.

(1) Data source and data site information must be submitted on all ADT transactions. (0.5 percent)

(2) Event type must be properly coded on all ADT transactions. (0.5 percent)

(3) Patient class must be properly coded on all appropriate ADT transactions. (0.5 percent)

(4) Patient demographic information must be submitted on all ADT transactions. (0.5 percent)

(5) Overall completeness of the ADT message. (0.5 percent)

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA (a fully signed copy of a CCA with an IHS/Tribal 638 facility is also acceptable). By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets the criteria specified in subsections (2)(a) or (b):

a. By April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved:

i. No later than April 1, 2021, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved.

ii. No later than May 1, 2021, or by the hospital’s go-live date for new data suppliers, or within 30 days of initiating the respective COVID-19 related services for current data suppliers, the hospital must complete the following COVID-19 related milestones, if they are applicable:

(1) Related to COVID-19 testing services, submit all COVID-19 lab test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(2) Related to COVID-19 antibody testing services, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE organization to ensure proper processing of lab results within the HIE system.

(3) Related to COVID-19 immunization services, submit all COVID-19 immunization codes and the associated CDISC—recognized codes to the qualifying HIE organization to ensure proper processing of immunizations within the HIE system.
iv. No later than May 1, 2021, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate and complete a data quality improvement effort, as defined by the qualifying HIE organization.

vi. No later than November 1, 2021, the hospital must approve and authorize a formal SOW to initiate connectivity to a SDOH Closed Loop Referral Platform operated by the qualifying HIE organization.

vii. No later than January 1, 2022, the hospital must complete the initial data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

viii. No later than May 1, 2022, the hospital must complete the final data quality profile with a qualifying HIE organization, in alignment with the data quality improvement SOW.

ix. Quality Improvement Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases described below:

1. Demonstrate a 10 percent improvement from baseline measurements in the initial data quality profile, based on July 2020 data, to the final data quality profile, based on March 2021 data.

2. Meet a minimum performance standard of at least 60 percent based on March 2021 data.

3. If performance meets or exceeds an upper threshold of 90 percent based on March 2021 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

x. DAP HIE Data Quality Standards CYE 2022 Measure Categories: Hospitals that meet the standards, as defined in Attachment A of this notice, qualify for a 2.0 percent DAP increase for each category of the five measure categories, for a total potential increase of 10.0 percent if criteria are met for all categories.

b. By March 15, 2021, the facility must submit a LOI to enter into a CCA with an IHS/Tribal 638 facility. By April 30, 2021, the facility must have entered into a CCA with a IHS/Tribal 638 facility for inpatient, outpatient, and ambulatory services provided through a referral under the executed CCA. The facility agrees to achieve and maintain participation in the following activities:

i. The facility will have in place a signed CCA with an IHS/Tribal 638 facility and will have submitted the signed CCA to AHCCCS. The CCA will meet minimum requirements as outlined in the CMS SHO Guidance.

ii. The facility will have a valid referral process for IHS/Tribal 638 facilities in place for requesting services to be performed by the non-IHS/Tribal 638 facility.

iii. The hospital will provide to the IHS/Tribal 638 facility clinical documentation of services provided through a referral under the CCA.

iv. AHCCCS will monitor activity specified under the CCA(s) to ensure compliance. To help facilitate this, the facility will participate in the HIE or establish an agreed claims operation process with AHCCCS for the review of medical records by May 31, 2021.

Historical Note
36-2903.01. Additional powers and duties; report; definition

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

   (a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

   (b) Establish performance measures and incentives for the department.

   (c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

   (d) Establish eligibility quality control reviews by the administration.

   (e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

   (f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

   (g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

   (h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months.
after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and
medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio.
ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall
include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.
(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H
or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

(a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

(b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

(c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.
L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.
2. A copayment of five dollars for each physician office visit.

3. A copayment of ten dollars for each urgent care visit.

4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
Title 9, Chapter 28

Amend: R9-28-702
Summary:

This regular rulemaking from the Arizona Health Care Cost Containment System (AHCCCS) seeks to amend one (1) rule in Title 9, Chapter 28, Article 7 related to Standards for Payments. Specifically, AHCCCS seeks to amend rule R9-28-702 to specify the rate that will be assessed for each reported nursing facility bed day beginning October 1, 2022.

AHCCCS indicates its Nursing Facility Assessment Program is designed to enhance reimbursement for Medicaid nursing facilities bed days using assessment funds to match federal funds. Nursing facilities that are assessed are outlined in statute and rule. AHCCCS indicates nursing facilities are paid these assessment and federal funds based on Medicaid bed days. AHCCCS states the proposed rule represents the AHCCCS Administration’s efforts to enhance reimbursement for a critical area of the health care delivery system.

1. Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?

AHCCCS cites cites both general and specific statutory authority for these rules.
2. **Do the rules establish a new fee or contain a fee increase?**

   This rulemaking does not establish a new fee or contain a fee increase.

3. **Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely upon?**

   AHCCCS indicates it did not review or rely on any study in conducting this rulemaking.

4. **Summary of the agency’s economic impact analysis:**

   According to AHCCCS, the rule will support economic development in Arizona, and it will promote the fiscal health of nursing facility providers by funding a larger portion of the costs related to care delivery. AHCCCS indicates that the rulemaking will amend the current rule to increase the amount of nursing facility provider assessment charged for health care items and services provided by nursing facilities authorized by State Law A.R.S. § 36-2999.51 et seq. AHCCCS anticipates that the rulemaking will result in approximately $29.9 million of net additional payments for the contract year October 1, 2022 through September 30, 2023 to 124 providers. Stakeholders include AHCCCS and nursing facilities which provide medical services to AHCCCS members.

5. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   AHCCCS states they did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State’s fiduciary responsibility to Arizona taxpayers.

6. **What are the economic impacts on stakeholders?**

   AHCCCS anticipates that the proposed rule changes will only affect nursing facilities. AHCCCS indicates that the rulemaking does not directly affect political subdivisions or small businesses. AHCCCS states that the rule does not impose compliance or reporting requirements beyond those already necessary to comply with federal and state statute. AHCCCS states the rule will not directly affect private persons and consumers.

7. **Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?**

   AHCCCS indicates there were no changes to the rules between the Notice of Proposed Rulemaking published in the Administrative Register and the Notice of Final Rulemaking now before the Council.
8. **Does the agency adequately address the comments on the proposed rules and any supplemental proposals?**

AHCCCS indicates it received four (4) comments in support of this rulemaking, which are summarized in Section 11 of the Preamble. Copies of the comments are also provided with the final materials for the Council’s reference.

Council staff believes AHCCCS has adequately addressed the comments related to this rulemaking.

9. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. AHCCCS indicates that the rules do not require a permit, license, or agency authorization.

10. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates that the rules are not more stringent than corresponding federal law.

11. **Conclusion**

AHCCCS seeks to amend one (1) rule in Title 9, Chapter 28, Article 7 related to Standards for Payments. Specifically, AHCCCS seeks to amend rule R9-28-702 to specify the rate that will be assessed for each reported nursing facility bed day beginning October 1, 2022.

AHCCCS is requesting an immediate effective date for this rulemaking pursuant to A.R.S. § 41-1032. Specifically, AHCCCS indicates that this rulemaking provides a benefit to the public and a penalty is not associated with a violation of the rule. See A.R.S. § 41-1032(A)(4).

Council staff believes AHCCCS has provided adequate justification for an immediate effective date for the rules. Council staff recommends approval of this rulemaking.
July 19, 2022

VIA EMAIL: grrc@azdoa.gov

Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: R9-28-702 Rulemaking

Dear Ms. Sorenson:

1. The close of record date:       7/5/2022
2. Does the rulemaking activity relate to a Five Year Review Report:   No
   a. If yes, the date the Council approved the Five Year Review Report: N/A
3. Does the rule establish a new fee: No
   a. If yes, what statute authorizes the fee: N/A
4. Does the rule contain a fee increase: No
5. Is an immediate effective date requested pursuant to A.R.S. 41-1032: Yes

AHCCCS certifies that the preamble discloses a reference to any study relevant to the rule that the agency reviewed. AHCCCS certifies that the preamble states that it did not rely on any such study in the agency’s evaluation of or justification for the rule.

AHCCCS certifies that the preparer of the economic, small business, and consumer impact statement has notified the Joint Legislative Budget Committee of the number of new full-time employees necessary to implement and enforce the rule.
The following documents are enclosed:

1. Notice of Final Rulemaking, including the preamble, table of contents, and text of each rule;

2. An economic, small business, and consumer impact statement that contains the information required by A.R.S. 41-1055;

3. If applicable: The written comments received by the agency concerning the proposed rule and a written record, transcript, or minutes of any testimony received if the agency maintains a written record, transcript or minutes;

4. If applicable: Any analysis submitted to the agency regarding the rule’s impact on the competitiveness of businesses in this state as compared to the competitiveness of business in other states;

5. If applicable: Material incorporated by reference;

6. General and specific statutes authorizing the rules, including relevant statutory definitions; and

7. If applicable: If a term is defined in the rule by referring to another rule or a statute other than the general and specific statutes authorizing the rule, the statute or other rule referred to in the definition.

Sincerely,

Kasey Rogg

Kasey Rogg
Assistant Director

Attachments
NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable)          Rulemaking Action:
R9-28-702          Amend

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):
   Authorizing statute: A.R.S. §§ 36-2903.01, 36-2903, 36-2932
   Implementing statute: A.R.S. §§ 36-2999.52, 36-2999.54

3. The effective date of the rule:
   As specified in A.R.S. § 41-1032(A)(4), the agency requests an immediate effective date to provide a benefit to the public and a penalty is not associated with a violation of the rule.

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

5. The agency’s contact person who can answer questions about the rulemaking:
6. **An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

AHCCCS Nursing Facility Assessment Program is designed to enhance reimbursement for Medicaid nursing facilities bed days using assessment funds to match federal funds. Nursing facilities that are assessed are outlined in statute and rule. Nursing facilities are paid these assessment and federal funds based on Medicaid bed days. The proposed rule represents the AHCCCS Administration’s efforts to enhance reimbursement for a critical area of the health care delivery system. The proposed rulemaking will amend rules specifying the rate that will be assessed for each reported bed day beginning October 1, 2022.

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

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

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

Not applicable.

9. A summary of the economic, small business, and consumer impact:

The Administration anticipates that the Nursing Facilities Assessment rulemaking will result in approximately $29.9 million of net additional payments for the contract year October 1, 2022 through September 30, 2023 to 124 providers.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

There were no changes between the proposed and final rulemakings.

11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

<table>
<thead>
<tr>
<th>Name and Position of Commenter</th>
<th>Date of Comment</th>
<th>Text of Comment</th>
<th>AHCCCS Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brett P. Robertson,</td>
<td>6/10/2022</td>
<td>I write today to express my support of the proposed rulemaking amendment to the long-term care provider assessment. As</td>
<td>AHCCCS thanks Haven Health Group for their</td>
</tr>
</tbody>
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you know, the last two years have been unbelievably difficult for skilled nursing facilities, we have faced long odds to keep our patients safe and our staff happy. Each and every day brings a new challenge to our business, and this proposed amendment to the provider assessment gives us much needed financial backing to continue to recruit care givers back to our sector, as well as prevent them from leaving. Each day we see employees leave the skilled nursing work force due to the strenuous nature of the job and having the ability to reward key employees with additional dollars will make a huge difference. As the largest rural nursing home operator in the state, we see first-hand, every day, just how much more expensive life is for our staff as well as for our business. The cost of food, medication, medical supplies, and labor have skyrocketed over the last two years. These increases, coupled with a decrease in occupancy make any additional dollars available to us more meaningful than during ordinary times. Please know that Haven Health Group and its 18 skilled nursing facilities and three assisted living facilities unequivocally support the provider tax amendment and know that it will have a direct impact on the viability of the nursing home network in Arizona.

Mason A. Hunter, President, Haven Health Group
6/13/2022
I am writing regarding the proposed rulemaking amendment to the long-term provider assessment. Throughout the last two years we have experienced the hardest operational and clinical challenges we have ever seen. Every one of our 18 facilities are facing significant challenges that require every resource possible to overcome. We have seen the cost of labor, medical supplies, medicine, food, uniforms, linens, and all other items necessary for skilled nursing care balloon significantly over the past two years. In

AHCCCS thanks Health Group Management for their support of this rulemaking.
addition to these rising costs, our staff have personally been negatively impacted by the rapid rise of inflation and cost of goods. As a result of the pandemic, we have also seen our occupancy decrease, which makes these additional dollars even that much more helpful. We are truly caring for Arizona’s most vulnerable population, with limited resources. These dollars make a big impact in our ability to seek and retain quality staff, purchase needed supplies and ultimately give the care our residents deserve. These dollars have a direct impact on the lives of Arizona’s elderly.

| Heather Friebus, Administrator Devon Gables/AHC A Board President | 7/5/2022 | Thank you for the opportunity to comment on the AHCCCS Notice of Proposed Rulemaking amending the long term care provider assessment. As President of Arizona Health Care Association (AHCA) and Administrator of Devon Gables Rehabilitation this is very important to the bottom line for Devon Gables and many of our members. AHCA and Devon Gables Rehabilitation Center completely and unequivocally support the proposed rule and encourage its implementation. The COVID-19 pandemic and subsequent inflationary price increases have placed major pressures on Devon Gables Rehabilitation Center. Nurses and care givers are demanding increased salaries, and cost of goods has risen to the highest I have ever seen in the last 15 years as Administrator here at Devon Gables. This proposed rule increases the assessed dollars to facilities like Devon Gables and provides additional revenue to the long term care community with over $29 million of much needed funding. This funding is provider driven and does not impact the state of Arizona. Devon Gables serves of 150 AHCCCS members and without this funding we

| AHCCCS thanks Devon Gables for their support of this rulemaking. |
would not survive financially. I have worked at Devon Gables for over 30 years and they are my second family, I pride myself on having low turnover and thus keeping my residents happy in their home here at the facility. I have had to offer housing in my Independent living apartments to some of my Certified Nursing assistants who have lost their homes. This is a devasting state of affairs for so many and I appreciate the opportunity to share my experience and how meaningful the Long Term Care Provider Assessment is for not only Devon Gables, but many of the AHCA members who serve our very vulnerable population.

David A. Voepel, CEO, AHCA

6/10/2022

Thank you for the opportunity to comment on the Arizona Health Care Cost Containment System (AHCCCS) Notice of Proposed Rulemaking amending the long term care provider assessment. The Arizona Health Care Association (AHCA) is the largest statewide non-profit association representing skilled nursing facilities and assisted living communities with over 180 members. AHCA completely and unequivocally supports this proposed rule and encourages its implementation. The COVID-19 pandemic and subsequent inflationary price increases have placed major pressures on skilled nursing facilities in Arizona. This proposed rule increases the assessed dollars to facilities and provides additional revenue to the long term care community with over $29 million of much needed funding. This funding is provider driven and does not impact the state of Arizona. Without these additional dollars and the continued support of AHCCCS, long term care services and supports would face continued peril.

Thank you for your public comments regarding the Long Term Care Assessment expedited rulemaking. The Association's support of AHCCCS changes is appreciated.
12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

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

Not applicable.

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

Not applicable.

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

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:
None.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:
TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-28-702 Nursing Facility Assessment
ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-702. Nursing Facility Assessment

A. For purposes of R9-28-702 and R9-28-703, in addition to the definitions under A.R.S. § 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

“820 transaction” means the standard health care premium payments transaction required by 45 CFR 162.1702.

“Assessment year” means the 12 month period beginning October 1st each year.

“Medicaid patient days” means patient days reported on the Nursing Care Institution Uniform Accounting Report (UAR) as attributable to AHCCCS and its contractors as the primary payer.

“Medicare days” means resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payer.

“Medicare patient days” means patient days reported on the Nursing Care Institution UAR as Skilled Medicare Patient Days or Part C/Advantage/Medicare Replacement Days.

“Nursing Care Institution UAR” means the Nursing Care Institution Uniform Accounting Report described by R911-204.

B. Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.
C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:

1. A continuing care retirement community,
2. A facility with 58 or fewer beds, according to the Arizona Department of Health Services, Division of Licensing Services, Provider & Facility Database,
3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Intellectually Disabled,
4. A tribally owned or operated facility located on a reservation, or
5. Arizona Veteran’s Homes, or
6. Facilities located outside of the State of Arizona

D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:

1. In September of each year, the Administration shall obtain from the Arizona Department of Health Services the most recently published Nursing Care Institution UAR and the information required in subsection (C)(2). At the request of the Administration, a nursing facility shall provide the Administration with any additional information necessary to determine the assessment.

2. The Administration shall use the information obtained under subsection (D)(1) to determine:
   a. Each nursing facility’s total annual Medicaid patient days,
   b. Each nursing facility’s total annual Medicare patient days,
   c. Each nursing facility’s total annual patient days,
   d. The aggregate net patient service revenue of all assessed providers, and
e. The slope described under 42 CFR 433.68(e)(2).

3. For each nursing facility, other than a nursing facility exempted in subsection (C) or described in subsection (D)(4), the provider assessment is calculated by multiplying the nursing facility’s total annual patient days, other than Medicare patient days, by $15.63-20.80.

4. For a nursing facility, other than a nursing facility exempted in subsection (C), with the number of total annual Medicaid patient days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility’s total annual patient days, other than Medicare patient days, by $1.80-2.40.

5. For each assessment year the slope described under 42 CFR 433.68(e)(2) shall be recalculated.

6. The assessment calculated under subsections (D)(3), (D)(4) and (D)(5), shall not exceed 3.5 percent of the aggregate net patient service revenue of all assessed providers as reported on the Nursing Care Institution UAR obtained under subsection (D)(1). If the rates listed in (D)(3) and (D)(4) produce a total annual assessment that exceeds 3.5 percent of the aggregate net patient service revenue of all assessed providers as reported on the Nursing Care Institution UAR obtained under subsection (D)(1), the rates listed in (D)(3) and (D)(4) will be reduced to not exceed the 3.5 percent limit.

7. All calculations and determinations necessary for the provider assessment shall be based on information possessed by the Administration on or before November 1.
of the assessment year.

8. The Administration will forward the provider assessment by facility to the Arizona Department of Revenue on or before December 1 of the assessment year.

9. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.

10. In the event a nursing facility begins operation during the assessment year, that facility will have no responsibility for the assessment until such time as the facility has submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation.

11. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.
ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION – ARIZONA LONG TERM CARE SYSTEM

Introduction:
The rule will support economic development in Arizona, and it will promote the fiscal health of nursing facility providers by funding a larger portion of the costs related to care delivery. By continuing to make available increased assessment payments to nursing facilities, the proposed rulemaking will also enhance the ability of nursing facilities to provide higher quality yet cost-effective care to AHCCCS members who receive nursing facility services. The assessment payments to nursing facilities will foster economic growth within the State. The proposed rulemaking will promote health care delivery, innovation, and economic development in Arizona. The proposed rulemaking will reduce the regulatory burden upon stakeholders by continuing the availability of increased payments to nursing facilities.

Purpose of Rule:
This final rulemaking will amend the current rule to increase the amount of the nursing facility provider assessment charged for health care items and services provided by nursing facilities authorized by State Law A.R.S. § 36-2999.51 et seq. The statutory scheme requires the AHCCCS Administration to administer a provider assessment (also referred to as a quality assessment) on health care items and services provided by nursing facilities and to make supplemental payments to nursing facilities for covered Medicaid expenditures. As a result of the
final rulemaking which will increase the dollar amount of the nursing facility assessment in R9-28-702, additional supplemental funding will be available to nursing facilities for covered Medicaid expenditures, thus supporting accessibility of critical health care services to vulnerable populations and enhancing the ability of nursing facilities to provide higher quality yet cost-effective care to frail Arizona residents.

1. **Identification of rulemaking.**

   AHCCCS Nursing Facility Assessment Program is designed to enhance reimbursement for Medicaid nursing facilities bed days using assessment funds to match federal funds. Nursing facilities that are assessed are outlined in statute and rule. Nursing facilities are paid these assessment and federal funds based on Medicaid bed days. The proposed rule represents the AHCCCS Administration’s efforts to enhance reimbursement for a critical area of the health care delivery system. The proposed rulemaking will amend rules specifying the rate that will be assessed for each reported bed day beginning October 1, 2022.

   **a. The conduct and its frequency of occurrence that the rule is designed to change:**

   The changes to this rule revise the method of calculating allowable indirect costs. This calculation is performed annually.

   **b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:**

   The Administration does not anticipate a change in conduct with the rulemaking.
c. The estimated change in frequency of the targeted conduct expected from the rule change:

The Administration does not anticipate a change in frequency in conduct with the clarification of the indirect cost calculation. It is anticipated that participants who receive the nursing facility assessment payments will continue regular participation going forward.

2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.

The nursing facilities which provide medical services to AHCCCS members, and the Administration, are the parties that will either bear the costs or directly benefit from the rulemaking.

3. Cost benefit analysis.

a. Probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking including the number of new full-time employees necessary to implement and enforce the proposed rule:

i. Cost:

The Administration anticipates no increase in cost to the implementing agency.

ii. Benefit:

The Administration anticipates no specific benefit to the implementing agencies.
iii. Need for additional Full-time Employees:

The Administration does not anticipate the need to hire full-time employees as a result of this rulemaking.

b. Probable costs and benefits to political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

This rulemaking does not directly affect political subdivisions.

4. General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.

The Administration anticipates that any change to public and private employment will be an increase in employment due to the additional funding.

5. Statement of probable impact of the proposed rule on small businesses. The statement shall include:

a. Identification of the small businesses subject to the proposed rulemaking.

The Administration does not anticipate a fiscal impact on small businesses because the proposed rule language changes are anticipated to only affect nursing facilities and the Administration.
b. **Administrative and other costs required for compliance with the proposed rulemaking.**

The Administration anticipates no impact on the administrative expenses of these small businesses because the proposed rule does not require a change in claim submission coding or procedure.

c. **Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency’s decision to use or not use each method:**

i. **Establishing less stringent compliance or reporting requirements in the rule for small businesses:**

   This rule does not impose compliance or reporting requirements on small businesses beyond those already necessary to comply with federal law and state statute.

ii. **Establishing less stringent schedules deadlines in the rule for compliance or reporting requirements for small businesses:**

   This rule does not impose compliance or reporting requirements on small businesses beyond those requirements that are necessary to comply with federal law and state statute.

iii. **Consolidate or simplify the rule’s compliance or reporting requirements for small businesses:**
This rule does not impose compliance or reporting requirements on small businesses beyond those requirements that are necessary to comply with federal law and state statute.

iv. **Establish performance standards for small businesses to replace design or operational standards in the rule; and**

This rule does not establish performance standards for small businesses beyond those requirements that are necessary to comply with federal law and state statute.

v. **Exempting small businesses from any or all requirements of the rule.**

Exempting small businesses is not applicable to this rule.

d. **The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

The rule will not directly affect private persons and consumers.

6. **Statement of the probable effect on state revenues.**

It is anticipated that the rule will not affect state revenues.

7. **Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**
The Administration did not consider other alternatives because the revisions to the rule are the most cost effective and efficient method of complying with federal law and state law as well as the State’s fiduciary responsibility to Arizona taxpayers.

8. **A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data.**

The Administration did not consider any specific data to base the rule upon.
June 13, 2022

Jamie Snyder, Director
Arizona Health Care Cost Containment System
801 E. Jefferson St.
Phoenix, AZ 85034

Email: AHCCCSRules@azahcccs.gov

RE: Comments on AHCCCS Proposed Rulemaking – LTC Provider Assessment

Dear Director Snyder,

I am writing regarding the proposed rulemaking amendment to the long-term provider assessment. Throughout the last two years we have experienced the hardest operational and clinical challenges we have ever seen. Every one of our 18 facilities are facing significant challenges that require every resource possible to overcome. We have seen the cost of labor, medical supplies, medicine, food, uniforms, linens, and all other items necessary for skilled nursing care balloon significantly over the past two years. In addition to these rising costs, our staff have personally been negatively impacted by the rapid rise of inflation and cost of goods. As a result of the pandemic, we have also seen our occupancy decrease, which makes these additional dollars even that much more helpful. We are truly caring for Arizona’s most vulnerable population, with limited resources. These dollars make a big impact in our ability to seek and retain quality staff, purchase needed supplies and ultimately give the care our residents deserve. These dollars have a direct impact on the lives of Arizona’s elderly. Please reach out to me anytime with any questions you may have.

Sincerely,

Mason A. Hunter
President of Operations-Arizona
Haven Health Group
714-337-3984
June 10, 2022

Jami Snyder, Director
Arizona Health Care Cost Containment System
801 E. Jefferson St.
Phoenix, AZ 85034

Via email: AHCCCSRules@azahcccs.gov

RE: Comments on AHCCCS Proposed Rulemaking – LTC Provider Assessment

Dear Director Snyder,

I write today to express my support of the proposed rulemaking amendment to the long-term care provider assessment. As you know, the last two years have been unbelievably difficult for skilled nursing facilities, we have faced long odds to keep our patients safe and our staff happy. Each and every day brings a new challenge to our business, and this proposed amendment to the provider assessment gives us much needed financial backing to continue to recruit care givers back to our sector, as well as prevent them from leaving. Each day we see employees leave the skilled nursing work force due to the strenuous nature of the job and having the ability to reward key employees with additional dollars will make a huge difference. As the largest rural nursing home operator in the state, we see first-hand, every day, just how much more expensive life is for our staff as well as for our business. The cost of food, medication, medical supplies, and labor have skyrocketed over the last two years. These increases, coupled with a decrease in occupancy make any additional dollars available to us more meaningful than during ordinary times. Please know that Haven Health Group and its 18 skilled nursing facilities and three assisted living facilities unequivocally support the provider tax amendment and know that it will have a direct impact on the viability of the nursing home network in Arizona. Please don’t hesitate to contact me directly with any questions or concerns.

Respectfully,

Brett P. Robertson
480-935-4300
Chief Executive Officer
Haven Health Group
June 10, 2022

Jami Snyder, Director
Arizona Health Care Cost Containment System
801 E. Jefferson St.
Phoenix, AZ 85034

Via email: AHCCCSRules@azahccc.gov

RE: Comments on AHCCCS Proposed Rulemaking – Long Term Care Provider Assessment

Dear Director Snyder:

Thank you for the opportunity to comment on the Arizona Health Care Cost Containment System (AHCCCS) Notice of Proposed Rulemaking amending the long term care provider assessment. The Arizona Health Care Association (AHCA) is the largest statewide non-profit association representing skilled nursing facilities and assisted living communities with over 180 members.

AHCA completely and unequivocally supports this proposed rule and encourages its implementation.

The COVID-19 pandemic and subsequent inflationary price increases have placed major pressures on skilled nursing facilities in Arizona. This proposed rule increases the assessed dollars to facilities and provides additional revenue to the long term care community with over $29 million of much needed funding. This funding is provider driven and does not impact the state of Arizona. Without these additional dollars and the continued support of AHCCCS, long term care services and supports would face continued peril putting at risk the network available for our most frail and vulnerable.

Thank you, once again, for the opportunity to offer comment. Should you have questions please do not hesitate to contact me.

Sincerely,

[Signature]

David A. Voepel
CEO
July 5, 2022  
Jami Snyder, Director  
Arizona Health Care Cost Containment System  
801 E. Jefferson St.  
Phoenix, Az 85034  
Via email: AHCCCSRules@azahcccs.gov

Re: Comments on AHCCCS Proposed Rulemaking- Long Term Care Provider Assessment  

Dear Director Snyder:

Thank you for the opportunity to comment on the AHCCCS Notice of Proposed Rulemaking amending the long term care provider assessment. As President of Arizona Health Care Association (AHCA) and Administrator of Devon Gables Rehabilitation this is very important to the bottom line for Devon Gables and many of our members.

AHCA and Devon Gables Rehabilitation Center completely and unequivocally support the proposed rule and encourage its implementation.

The COVID-19 pandemic and subsequent inflationary price increases have placed major pressures on Devon Gables Rehabilitation Center. Nurses and care givers are demanding increased salaries, and cost of goods has risen to the highest I have ever seen in the last 15 years as Administrator here at Devon Gables. This proposed rule increases the assessed dollars to facilities like Devon Gables and provides additional revenue to the long term care community with over $29 million of much needed funding. This funding is provider driven and does not impact the state of Arizona. Devon Gables serves over 150 AHCCCS members and without this funding we would not survive financially. I have worked at Devon Gables for over 30 years and they are my second family, I pride myself on having low turnover and thus keeping my residents happy in their home here at the facility. I have had to offer housing in my Independent living apartments to some of my Certified Nursing assistants who have lost their homes. This is a devastating state of affairs for so many and I appreciate the opportunity to share my experience and how meaningful the Long Term Care Provider Assessment is for not only Devon Gables, but many of the AHCA members who serve our very vulnerable population.

Sincerely,

Heather Friebus  
Administrator Devon Gables/AHCA Board President
For purposes of R9-28-702 and R9-28-703, in addition to the definitions under A.R.S. § 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

“820 transaction” means the standard health care premium payments transaction required by 45 CFR 162.1702.

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“Nursing Care Institution UAR” means the Nursing Care Institution Uniform Accounting Report described by R9-11-204.

B. Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.

C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:

1. A continuing care retirement community,
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3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Intellectually Disabled,
4. A tribally owned or operated facility located on a reservation, or
5. Arizona Veteran’s Homes.

D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:

1. In September of each year, the Administration shall obtain from the Arizona Department of Health Services the most recently published Nursing Care Institution UAR and the information required in subsection (C)(2). At the request of the Administration, a nursing facility shall provide the Administration with any additional information necessary to determine the assessment.

2. The Administration shall use the information obtained under subsection (D)(1) to determine:

   a. Each nursing facility’s total annual Medicaid patient days,
   b. Each nursing facility’s total annual Medicare patient days,
   c. Each nursing facility’s total annual patient days,
   d. The aggregate net patient service revenue of all assessed providers, and
   e. The slope described under 42 CFR 433.68(e)(2).

3. For each nursing facility, other than a nursing facility exempted in subsection (C) or described in subsection (D)(4), the provider assessment is calculated by multiplying the nursing facility’s total annual patient days, other than Medicare patient days, by $15.63.

4. For a nursing facility, other than a nursing facility exempted in subsection (C), with a number of total annual Medicaid patient days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).
multiplying the nursing facility’s total annual patient days, other than Medicare patient days, by $1.80.
5. For each assessment year the slope described under 42 CFR 433.68(e)(2) shall be recalculated.
6. The total annual assessment calculated under subsections (D)(3), (D)(4) and (D)(5), shall not exceed 3.5 percent of the aggregate net patient service revenue of all assessed providers as reported on the Nursing Care Institution UAR obtained under subsection (D)(1).
7. All calculations and determinations necessary for the provider assessment shall be based on information possessed by the Administration on or before November 1 of the assessment year.
8. The Administration shall forward the provider assessments for all assessed facilities to the Arizona Department of Revenue on or before December 1 of the assessment year.
9. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.
10. In the event a nursing facility begins operation during the assessment year, that facility will have no responsibility for the assessment until such time as the facility has submitted to the Arizona Department of Health Services the report required by R9-11-204(A) covering a full year of operation.
11. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.

Historical Note

R9-28-703. Nursing Facility Supplemental Payments
A. Determination of amounts available for payment.
1. Using Medicaid resident bed day information from the most recent and complete 12 months of paid claim and adjudicated encounter data, for every facility eligible for a supplemental payment, the Administration shall determine annually:
   a. A ratio equal to the number of bed days paid by the Administration’s contractors divided by the total number of bed days paid, and
   b. A ratio equal to the number of bed days paid by the Administration divided by the total number of bed days paid.
2. The Administration shall determine quarterly the amount available in the nursing facility assessment fund established by A.R.S. § 36-2999.53 plus the corresponding federal financial participation and divide the total amount as follows:
   a. The total amount multiplied by the ratio determined in subsection (A)(1)(a) shall be distributed according to subsection (B).
   b. The total amount multiplied by the ratio determined in subsection (A)(1)(b) shall be distributed according to subsection (C).
B. Payments to facilities by contractors.
1. The Administration shall distribute quarterly to its contractors an amount equal to the total amount of Nursing Facility Enhanced Payments made by the Administration’s contractors for the period of October 1, 2015 through September 30, 2016 divided by 4, which shall be paid to eligible facilities as follows:
   a. Using the adjudicated encounter data described in subsection (A)(1), the Administration shall determine annually for each facility a ratio equal to the number of bed days for the facility paid by each contractor divided by the total number of bed days paid to all facilities by all contractors.
   b. Each contractor shall make payments quarterly to each facility in an amount equal to 98% of the amounts identified as Nursing Facility Enhanced Payments in the 820 transaction sent by the Administration to the contractor for the quarter multiplied by the ratio determined in subsection (B)(1)(a) applicable to the contractor and to each facility. In the event the Administration does not produce an 820 transaction, each contractor shall distribute quarterly an amount equal to 98% of the payment received from AHCCCS for Nursing Facility Enhanced Payments.
   c. Contractors shall not be required to make quarterly payments to a facility until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced Payments based on actual member months for the specified quarter.
   d. Beginning October 1, 2018, any amounts that would otherwise have been distributed under subsection (B)(1) shall be distributed under subsection (B)(2).
2. Subject to annual approval by CMS in accordance with 42 CFR § 438.6(c), the Administration shall distribute quarterly to its contractors an amount equal to the amount determined in subsection (A)(2)(a) minus the amount distributed under subsection (B)(1), which shall be paid to eligible facilities as follows:
   a. Using the Medicaid resident bed day information described by subsection (A)(1), the Administration shall determine quarterly a per bed day enhanced support uniform increase by dividing the quarterly distribution amount by one fourth of the total resident bed days paid by the Administration’s contractors. Using the same Medicaid resident bed day information, the Administration shall determine the quarterly bed days paid to each facility by each contractor by summing the total bed days paid to each facility by each contractor and dividing by 4.
   b. The Administration shall communicate to the contractors quarterly the per bed day enhanced support uniform increase and the quarterly bed days paid to each facility by the contractor.
   c. Each contractor shall distribute quarterly an amount equal to 98% of the payment received from AHCCCS, to be paid to each facility in an amount equal to the per bed day enhanced support uniform increase multiplied by the per bed day enhanced support uniform increase and the quarterly bed days paid to each facility by the contractor.
A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the
system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting
provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that
relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the
applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a
person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as
prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the
eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option,
the interagency agreement may allow the administration to determine the eligibility of certain persons, including those
defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:
   (a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.
   (b) Establish performance measures and incentives for the department.
   (c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility
determination functions performed by the department.
   (d) Establish eligibility quality control reviews by the administration.
   (e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that
applicants or members may use for appeals of eligibility determinations or redeterminations.
   (f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to
screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are
screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be
accepted on a twenty-four hour basis, seven days a week.
   (g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure
to meet performance measures required by the intergovernmental agreement.
   (h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility
determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a
strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation
of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding
sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time
frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system
covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or
program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being
grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received
by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service,
within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim
submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity
of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the
claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The
administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any
proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented
by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:
   (a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.
   (b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:
   1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.
   2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.
   3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.
   4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:
1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.
(b) An itemized statement.
(c) An admission history and physical.
(d) A discharge summary or an interim summary if the claim is split.
(e) An emergency record, if admission was through the emergency room.
(f) Operative reports, if applicable.
(g) A labor and delivery room report, if applicable.
Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight
hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients,
the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:
   (a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.
   (b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.
   (c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil
penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.

2. A copayment of five dollars for each physician office visit.
3. A copayment of ten dollars for each urgent care visit.

4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.
A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

B. An agreement may be entered into with an independent contractor, subject to title 41, chapter 23, to serve as the statewide administrator of the system. The administrator has full operational responsibility, subject to supervision by the director, for the system, which may include any or all of the following:

1. Development of county-by-county implementation and operation plans for the system that include reasonable access to hospitalization and medical care services for members.

2. Contract administration and oversight of contractors, including certification instead of licensure for title XVIII and title XIX purposes.

3. Provision of technical assistance services to contractors and potential contractors.

4. Development of a complete system of accounts and controls for the system including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including but not limited to inpatient behavioral health services provided in a hospital. Periodically the administrator shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state in comparison with other states' health care services to identify any unnecessary or unreasonable utilization within the system. The administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the system in order to reduce unnecessary or unreasonable utilization.

5. Establishment of peer review and utilization review functions for all contractors.

6. Assistance in the formation of medical care consortiums to provide covered health and medical services under the system for a county.

7. Development and management of a contractor payment system.

8. Establishment and management of a comprehensive system for assuring the quality of care delivered by the system.

9. Establishment and management of a system to prevent fraud by members, subcontracted providers of care, contractors and noncontracting providers.

10. Coordination of benefits provided under this article to any member. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage.


12. Development and management of an enrollment system.

13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims shall be paid within thirty days of receipt and ninety-nine per cent of the remaining clean claims shall be paid within ninety days of receipt. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.

14. Establishment of standards for the coordination of medical care and patient transfers pursuant to section 36-2909, subsection B.
15. Establishment of a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.


17. Establishment of an eligibility process to determine whether a medicare low income subsidy is available to persons who want to apply for a subsidy as authorized by title XVIII.

C. If an agreement is not entered into with an independent contractor to serve as statewide administrator of the system pursuant to subsection B of this section, the director shall ensure that the operational responsibilities set forth in subsection B of this section are fulfilled by the administration and other contractors as necessary.

D. If the director determines that the administrator will fulfill some but not all of the responsibilities set forth in subsection B of this section, the director shall ensure that the remaining responsibilities are fulfilled by the administration and other contractors as necessary.

E. The administrator or any direct or indirect subsidiary of the administrator is not eligible to serve as a contractor.

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person who is covered by workers' compensation, disability insurance, a hospital and medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981, paragraph 6 unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this subsection are controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with the provisions of this subsection.

G. Notwithstanding subsection E of this section, the administrator may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

H. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

J. The director shall prescribe rules that specify methods for:

1. The transition of members between system contractors and noncontracting providers.

2. The transfer of members and persons who have been determined eligible from hospitals that do not have contracts to care for such persons.
K. The director shall adopt rules that set forth procedures and standards for use by the system in requesting county long-term care for members or persons determined eligible.

L. To the extent that services are furnished pursuant to this article, and unless otherwise required pursuant to this chapter, a contractor is not subject to title 20.

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and accomplish the orderly transition of those members to other system contractors, or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor and provides an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

N. The administration for the sole purpose of matters concerning and directly related to the Arizona health care cost containment system and the Arizona long-term care system is exempt from section 41-192.

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Q. Notwithstanding section 36-470, a contractor or program contractor may receive laboratory tests from a laboratory or hospital-based laboratory for a system member enrolled with the contractor or program contractor subject to all of the following requirements:

1. The contractor or program contractor shall provide a written request to the laboratory in a format mutually agreed to by the laboratory and the requesting health plan or program contractor. The request shall include the member's name, the member's plan identification number, the specific test results that are being requested and the time periods and the quality improvement activity that prompted the request.

2. The laboratory data may be provided in written or electronic format based on the agreement between the laboratory and the contractor or program contractor. If there is no contract between the laboratory and the contractor or program contractor, the laboratory shall provide the requested data in a format agreed to by the noncontracted laboratory.

3. The laboratory test results provided to the member's contractor or program contractor shall only be used for quality improvement activities authorized by the administration and health care outcome studies required by the administration. The contractors and program contractors shall maintain strict confidentiality about the test results and identity of the member as specified in contractual arrangements with the administration and pursuant to state and federal law.
4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

6. A laboratory that complies with a request from the contractor or program contractor for laboratory results pursuant to this section is not subject to civil liability for providing the data to the contractor or program contractor. The administration, the contractor or a program contractor that uses data for reasons other than quality improvement activities is subject to civil liability for this improper use.

R. For the purposes of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.
A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.
2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.
3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' requests for proposals for providers and provider subcontracts.
4. Providing technical assistance to the program contractors.
5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.
6. Conducting quality control on eligibility determinations and preadmission screenings.
7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.
8. Establishing an enrollment system.
9. Establishing a member case management tracking system.
10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.
11. Coordinating benefits as provided in section 36-2946.
12. Establishing standards for the coordination of services.
13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.
14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.
15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.
16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and posteligibility treatment of income pursuant to subsection L of this section.
17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.
18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall contract periodically as deemed necessary and as required by federal law for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for
a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules to specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules that provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

J. The director may apply for federal monies available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state monies appropriated for the administration of the system may be used as matching monies to secure federal monies pursuant to this subsection.

K. The director shall adopt rules that establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources that determine the portion of a member's income that shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.
2. The maintenance needs of a spouse or family at home in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.

3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract that does not conform to federal requirements or that may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.

2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.
A. Beginning October 1, 2012, the administration shall charge a quality assessment on health care items and services provided by nursing facilities in order to obtain federal financial participation in the services provided pursuant to this chapter. The administration shall use these monies for supplemental payments to nursing facilities for covered medicaid expenditures, not to exceed the medicare upper payment limit program requirements.

B. Each nursing facility shall pay the assessment prescribed pursuant to this section to the department of revenue for deposit on a quarterly basis in the nursing facility assessment fund established by section 36-2999.53.

C. Unless otherwise required by law, title 42, chapter 5, article 1 governs the administration of the assessment prescribed pursuant to this section except that:

1. A separate license is not required for the assessment.
2. If a nursing facility does not have a transaction privilege tax license, it shall obtain one pursuant to section 42-5005.
3. Each facility shall report and pay the assessment on forms prescribed by the department of revenue.
4. A separate bond is not required of employees of the department of revenue who administer the assessment.
5. The assessment may be included without segregation in any notice and lien filed for unpaid transaction privilege taxes.

D. The administration shall calculate the quality assessment on the net patient service revenue of all nursing facilities that are subject to the quality assessment. The quality assessment may not exceed three and one-half per cent of net patient service revenue and shall be calculated and paid on a per resident day basis exclusive of medicare resident days. Except as prescribed in this section, the per resident day assessment is the same amount for each affected facility.

E. Pursuant to 42 Code of Federal Regulations section 433.68(e)(1) and (2), the administration shall request a waiver of the broad-based and uniform provider assessment requirements of federal law to exclude certain nursing facilities from the quality assessment and to permit certain high volume medicaid nursing facilities or facilities with a high number of total annual patient days to pay the quality assessment at a lesser amount per nonmedicare resident day.

F. Subject to federal approval pursuant to 42 Code of Federal Regulations section 433.68(e)(2), the following nursing facility providers are exempt from the quality assessment:

2. Nursing facilities with fifty-eight or fewer beds.

G. The administration shall lower the quality assessment for either certain high volume medicaid nursing facilities or certain facilities with high patient volumes to meet the redistributive test of 42 Code of Federal Regulations section 433.68(e)(2).
A. Each nursing facility shall pay a quality assessment as prescribed pursuant to this article. The administration shall determine the assessment rate prospectively for the applicable fiscal year on a per resident day basis, exclusive of medicare resident days. The administration shall adopt rules for facility reporting of nonmedicare resident days and for payment of the assessment.

B. A nursing facility may increase its charges to other payors to incorporate the assessment but may not establish a separate line-item charge on the bill reflecting the assessment.

C. If an entity conducts, operates or maintains more than one nursing facility, the entity must pay a quality assessment for each nursing facility separately.

D. If a nursing facility does not pay the full amount of the assessment when due, the director of the Arizona health care cost containment system administration may suspend or revoke the nursing facility's Arizona health care cost containment system provider agreement registration. If the nursing facility does not comply within one hundred eighty days after the director of the Arizona health care cost containment system administration suspends or revokes the nursing facility's provider agreement, the director of the Arizona health care cost containment system administration shall notify the director of the department of health services, who shall suspend or revoke the nursing facility's license pursuant to section 36-427.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Title 9, Chapter 28, Articles 6, 7
Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relates to six (6) rules in Title 9, Chapter 28, Article 6 (RFP and Contract Process) and five (5) rules in Article 7 (Standards for Payments).

The rules in Article 6 relate to Request for Proposal and contract process for the Arizona Long-Term Care System (ALTCS). The ALTCS is health insurance for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. Services may be provided in an institution or in a home or community-based setting. Pursuant to A.R.S. 36-2944, the director at least every five years shall prepare and issue a request for proposal and a proposed contract format to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons to be a program contractor and provide long-term care services. The director may adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 28, Article 6.

The rules in Article 7 relate to Standards for Payments regarding ALTCS. Specifically, these rules describe general reimbursement requirements, the requirements for assessments to nursing facilities, the requirements for supplemental payments for nursing facilities, and the criteria for determining the county that is financially responsible for the state's share of the ALTCS funding as referenced in A.R.S. §36-2913.
In the previous 5YRR for these rules, approved by the Council in October 2017, AHCCCS did not indicate any proposed changes to the rules.

**Proposed Action**

In the current report, AHCCCS does not propose to make any changes to the rules.

1. **Has the agency analyzed whether the rules are authorized by statute?**
   
   AHCCCS cites both general and specific authority for these rules.

2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**
   
   AHCCCS indicates that for Articles 6 and 7 there has not been a rulemaking since the last 5YRR. Therefore, the economic impact is not significantly different from the original economic impact.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**
   
   AHCCCS believes the rules as written impose the least burden and cost when meeting their objectives.

4. **Has the agency received any written criticisms of the rules over the last five years?**
   
   AHCCCS indicates it has not received written criticisms of the rules in the last five years.

5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**
   
   AHCCCS indicates the rules are clear, concise, and understandable.

6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**
   
   AHCCCS indicates the rules are consistent with other rules and statutes.

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**
   
   AHCCCS indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**
   
   AHCCCS indicates the rules are enforced as written.
9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

   AHCCCS indicates the rules are not more stringent than corresponding federal law.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

    Not applicable. The rules do not require a permit, license, or agency authorization.

11. **Conclusion**

    This 5YRR relates to six (6) rules in Title 9, Chapter 28, Article 6 (RFP and Contract Process) and five (5) rules in Article 7 (Standards for Payments). AHCCCS indicates the rules are generally clear, concise, understandable, consistent, effective, and enforced as written. AHCCCS does not intend to take any action regarding these rules.

    Council staff recommends approval of this report.
January 28, 2022

**VIA EMAIL: grrc@azdoa.gov**

Nicole Sornsin, Chair  
Governor’s Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 28, Article 6, Five Year Review Report

Dear Ms. Sornsin:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 28, Article 6 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or nicole.fries@azahcccs.gov.

Sincerely,

Kasey Rogg  
Assistant Director

Attachments
1. **Authorization of the rule by existing statutes**

   General Statutory Authority: A.R.S. § 36-2932

   Implementing statute: A.R.S. §§ 36-2944, 36-2943, 36-2959, and 36-2999.51

2. **The objective of each rule:**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-28-601</td>
<td>The objective of the rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Title 9 Chapter 28 Article 6</td>
</tr>
<tr>
<td>R9-28-602</td>
<td>The objective of this rule is to prescribe the contents of the RFP and the proposal process.</td>
</tr>
<tr>
<td>R9-28-603</td>
<td>The objective of this rule is to prescribe the process the Administration follows when awarding contracts.</td>
</tr>
<tr>
<td>R9-28-604</td>
<td>The objective of this rule is to prescribe the means of protesting an RFP or award including the administrative appeal process.</td>
</tr>
<tr>
<td>R9-28-605</td>
<td>The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.</td>
</tr>
<tr>
<td>R9-28-606</td>
<td>The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.</td>
</tr>
</tbody>
</table>

3. **Are the rules effective in achieving their objectives?**

   Yes _X_ No __

4. **Are the rules consistent with other rules and statutes?**

   Yes _X_ No __

5. **Are the rules enforced as written?**

   Yes _X_ No __

6. **Are the rules clear, concise, and understandable?**

   Yes _X_ No __

7. **Has the agency received written criticisms of the rules within the last five years?**

   Yes __ No _X_

8. **Economic, small business, and consumer impact comparison:**

   There has not been a rulemaking since the last Five Year Review Report. Therefore, the economic impact is not significantly different than the original economic impact.

9. **Has the agency received any business competitiveness analyses of the rules?**

   Yes __ No _X_
10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**
   Not applicable.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**
   The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?**
    
    Yes ___  
    No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**
    Not applicable.

14. **Proposed course of action:**
   The agency did not provide any recommended changes to this article, therefore there is no proposed course of action.
January 28, 2022

VIA EMAIL: grrc@azdoa.gov

Nicole Sorns, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 28, Article 7, Five Year Review Report

Dear Ms. Sorns:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 28, Article 7 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or nicole.fries@azahcccs.gov.

Sincerely,

Kasey Rogg
Assistant Director

Attachments
1. **Authorization of the rule by existing statutes**
   
   General Statutory Authority: A.R.S. § 36-2932
   
   Implementing statute: A.R.S. §§ 36-2944, 36-2943, 36-2959, and 36-2999.51

2. **The objective of each rule:**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-28-701</td>
<td>The objective of this rule is to provide definitions that specifically support the payment regulations outlined in Article 7.</td>
</tr>
<tr>
<td>R9-28-701.10</td>
<td>The objective of this rule is to describe the general reimbursement requirements cross-referencing Chapter 28 reimbursement rules.</td>
</tr>
<tr>
<td>R9-28-702</td>
<td>The objective of this rule is to set forth the requirements for assessments to nursing facilities.</td>
</tr>
<tr>
<td>R9-28-703</td>
<td>The objective of this rule is to set forth the requirements for supplemental payments for nursing facilities.</td>
</tr>
<tr>
<td>R9-28-712</td>
<td>The objective of the rule is to set forth the criteria for determining the county that is financially responsible for the state's share of the ALTCS funding as referenced in A.R.S. §36-2913.</td>
</tr>
</tbody>
</table>

3. **Are the rules effective in achieving their objectives?**

   Yes _X_  No __

4. **Are the rules consistent with other rules and statutes?**

   Yes _X_  No __

5. **Are the rules enforced as written?**

   Yes _X_  No __

6. **Are the rules clear, concise, and understandable?**

   Yes _X_  No __

7. **Has the agency received written criticisms of the rules within the last five years?**

   Yes __  No _X_

8. **Economic, small business, and consumer impact comparison:**

   There has not been a rulemaking since the last Five Year Review Report. Therefore, the economic impact is not significantly different than the original economic impact.

9. **Has the agency received any business competitiveness analyses of the rules?**

   Yes __  No _X_

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**
Not applicable.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**
   The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?**
    Yes ___ No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**
    Not applicable.

14. **Proposed course of action:**
   The agency has no recommended changes, so there is no corresponding course of action proposed.
C. A program contractor shall submit a service plan and other information related to the case management plan upon request to the Administration.

Historical Note

A program contractor shall:
1. Comply with all requirements specified in A.A.C. R9-22-522; and

Historical Note

R9-28-512. Expired

Historical Note

R9-28-513. Program Compliance Audits
The Administration shall meet the requirements specified under A.A.C. R9-22-521 for a program contractor.

Historical Note

A. The Director has full operational authority to adopt rules for the RFP process and the award of contract under A.R.S. § 36-2944.
B. The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, subject to limitations and exclusions under that Article, unless otherwise specified in this Chapter.
C. The Administration shall award contracts under A.R.S. § 36-2932 to provide services under A.R.S. § 36-2939.
D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.
E. The Administration and contractors shall retain all records relating to contract compliance for five years under A.R.S. § 36-2932 and dispose of the records under A.R.S. § 41-2550.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-602. RFP
The ALTCS RFP for a program contractor serving members who are EPD shall meet the requirements of A.R.S. §§ 36-2944, A.R.S. § 36-2939, A.A.C. R9-22-602, and Articles 2 and 11 of this Chapter.

Historical Note
R9-28-603. Contract Award
The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-604. Contract or Proposal Protests; Appeals
Contract or proposal protests or appeals shall be under A.A.C. R9-22-604 and 9 A.A.C. 34.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-605. Waiver of Contractor’s Subcontract with Hospitals
A contractor’s subcontract with hospitals may be waived under A.A.C. R9-22-605.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-606. Contract Compliance Sanction
A. The Administration shall follow sanction provisions under A.A.C. R9-22-606.
B. The Administration shall apply remedies found in 42 CFR 488, Subpart F, effective January 1, 2012, incorporated by reference and on file with the Administration and the Office of the Secretary of State, for a nursing facility that does not meet requirements of participation under 42 U.S.C. 1396c. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-607. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-608. Repealed

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-609. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-610. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. Standards for Payment Related Definitions
Definitions. In this Article, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, the following phrase has the following meaning unless the context of the Article explicitly requires another meaning:
“County of fiscal responsibility” means the county that is financially responsible for the state’s share of ALTCS funding.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 8 A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-701.10. General Requirements
The following Sections of A.A.C. Chapter 22, Articles 2 and 7, are applicable to reimbursement for services provided under the ALTCS program, except that the term “program contractor” shall be substituted for “contractor.”
1. Scope of the Administration’s and Contractor’s Liability, R9-22-701.10;
2. Charges to Members, R9-22-702;
3. Payments by the Administration or by a program contractor, R9-22-703 and R9-22-705;
4. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
5. Payment for Non-hospital services, R9-22-710;
6. Specialty Contracts, R9-22-712(G)(3), R9-22-712.01 (10) and Article 2;
The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-604. Contract or Proposal Protests; Appeals
Contract or proposal protests or appeals shall be under A.A.C. R9-28-604 and 9 A.A.C. 34.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

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A contractor’s subcontract with hospitals may be waived under A.A.C. R9-22-605.

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Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective August 11, 1997 (Supp. 97-3). Section repealed by final rulemaking at 8 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

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2. Charges to Members, R9-22-702;
3. Payments by the Administration or by a program contractor, R9-22-703 and R9-22-705;
4. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care, R9-22-709;
5. Payment for Non-hospital services, R9-22-710;
6. Specially Contracts, R9-22-712(G)(3), R9-22-712.01 (10) and Article 2;
7. Payments by the Administration for Hospital Services Provided to an Eligible Person, R9-22-712; R9-22-712.01 and R9-22-712.10.
8. Overpayment and Recovery of Indebtedness, R9-22-713.
10. Hospital Rate Negotiations, R9-22-715; and

Historical Note
New Section made by final rulemaking at 13 A.A.R. 458, effective April 7, 2007 (Supp. 07-1).

R9-28-702. Repealed Nursing Facility Assessment
A. For purposes of this Section, in addition to the definitions under A.R.S. § 36-2999.51, the following terms have the following meaning unless the context specifically requires another meaning:

“820 transaction” means the standard health care premium payments transaction required by 45 CFR 162.1702.

“Assessment year” means the 12 month period beginning October 1st each year.

“Nursing Facility Assessment” means a tax paid by a qualifying nursing facility to the Department of Revenue on a quarterly basis established under A.R.S. § 36-2999.52.

“Medicaid days” means days of nursing facility services paid for by the Administration or its contractors as the primary payor and as reported in AHCCCS’ claim and encounter data.

“Medicare days” means resident days where the Medicare program, a Medicare advantage or special needs plan, or the Medicare hospice program is the primary payor.

“Payment year” means the 12 month period beginning October 1st each year: “Payment year” means the 12 month period beginning October 1st each year.

B. Subject to Centers for Medicare and Medicaid Services (CMS) approval, effective October 1, 2012, nursing facilities shall be subject to a provider assessment payable on a quarterly basis.

C. All nursing facilities licensed in the state of Arizona shall be subject to the provider assessment except for:
1. A continuing care retirement community,
2. A facility with 58 or fewer beds,
3. A facility designated by the Arizona Department of Health Services as an Intermediate Care Facility for the Mentally Retarded,
4. A tribally owned or operated facility located on a reservation, or
5. Arizona Veteran’s Homes.

D. The Administration shall calculate the prospective nursing facility provider assessment for qualifying nursing facilities as follows:
1. The Administration shall utilize each nursing facility’s Uniform Accounting Report (UAR) submitted to the Arizona Department of Health Services as of August 1st immediately preceding the assessment year. In addition, by August 1st each year, each nursing facility shall provide the Administration with any additional information necessary to determine the assessment. For any nursing facility that does not provide by August 1st the additional information requested by the Administration, the Administration shall determine the assessment based on the information available.

2. For each nursing facility, other than a nursing facility noted in subsection (D)(1), the provider assessment is calculated by multiplying the nursing facility’s non-Medicare resident day data for each assessment year by $7.50.

3. For a nursing facility with the number of annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2), the provider assessment is calculated by multiplying the nursing facility’s non-Medicare resident day data for each assessment year by $1.00.

4. The number of annual Medicaid days used in subsection (D)(3) shall be recalculated each August 1, to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2).

5. The assessment calculated under subsections (D)(2), (D)(3) and (D)(4), shall not exceed 3.5 percent of aggregate net patient service revenue of all assessed providers.

6. The Administration will forward the provider assessment by facility to the Department of Revenue by no later than December preceding the assessment year.

7. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be responsible for the portion of the assessment applied to the dates the nursing facility is not operating.

8. In the event a nursing facility begins operation during the assessment year, that facility would have no responsibility for the assessment until such time as the facility has UAR data that falls within the collection period for the assessment calculation.

9. In the event a nursing facility has a change of ownership such that the facility remains open and the ownership of the facility changes, the assessment liability transfers with the change in ownership.

Historical Note

R9-28-703. Nursing Facility Supplemental Payments
A. Nursing Facility Supplemental Payments
1. Using Medicaid resident bed day information from the most recent and complete twelve months of adjudicated claims and encounter data, for every combination of contractor and every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by each contractor divided by the total number of bed days paid to all facilities by all contractors and the Administration.

2. Using the same information as used in (A)(1), for every facility eligible for a supplemental payment, the Administration shall determine annually a ratio equal to the number of bed days for the facility paid by the Administration divided by the total number of bed days paid to all facilities by all contractors and the Administration.
3. Quarterly, each contractor shall make payments to each facility in an amount equal to 98% of the amounts identified as Nursing Facility Enhanced Payments in the 820 transaction sent from AHCCCS to the contractor for the quarter multiplied by the percentage determined in subsection (A)(2) applicable to the contractor and to each facility.

4. Quarterly, the Administration shall make payments to each facility in an amount equal to 99% of the amounts collected during the preceding quarter under R9-28-702, less amounts collected and used to fund the Nursing Facility Enhanced Payments included in the capitation paid to contractors and the corresponding federal financial participation, multiplied by the percentage determined in subsection (A)(2) applicable to the Administration and to each facility. The Administration shall make the supplemental payments to the nursing facilities within 20 calendar days of the determination of the quarterly supplemental payment.

5. Neither the Administration nor the Contractors shall be required to make quarterly payments to facilities otherwise required by subsections (A)(3) or (A)(4) until the assessment collected and actually available in the nursing facility assessment fund, plus the corresponding federal financial participation, are equal to or greater than 101% of the amount necessary for contractors to make the payments to facilities described in subsections (A)(4) and (A)(5).

6. Contractors shall not be required to make quarterly payments to facility otherwise required by subsection (A)(4) until the Administration has made a retroactive adjustment to the capitation rates paid to contractors to correct the Nursing Facility Enhanced payments based on actual member months for the specified quarter.

B. Each contractor must pay each facility the amount computed within 20 calendar days of receiving the nursing facility enhanced payment from the Administration. The contractors must confirm each payment and payment date to the Administration within 20 calendar days from receipt of the funds.

C. After each assessment year, the Administration shall reconcile the payments made by contractors under subsection (A) and (B) to the portion of the annual collections under R9-28-702 attributable to Medicaid resident bed days paid for by contractors for the same year, less one percent, plus available federal financial participation. The proportion of each nursing facility’s Medicaid resident bed days as described in subsection (A)(2)(ii) shall be used to calculate the reconciliation amounts. Contractors shall make additional payments to or recoup payments from nursing facilities based on the reconciliation in compliance with the requirements of subsection (B).

D. General requirements for all payments.

1. A facility must be open on the date the supplemental payment is made in order to receive a payment. In the event a nursing facility closes during the assessment year, the nursing facility shall cease to be eligible for supplemental payments.

2. In the event a nursing facility begins operation during the assessment year, that facility shall not receive a supplemental payment until such time as the facility has claims and encounter data that falls within the collection period for the payment calculation.

3. In the event a nursing facility has a change of ownership, payments shall be made to the owner of the facility as of the date of the supplemental payment.

4. Subsection (E)(3) shall not be interpreted to prohibit the current and prior owner from agreeing to a transfer of the payment from the current owner to the prior owner.

E. The Arizona Veterans’ Homes are not eligible for supplemental payments.

Historical Note
Editor’s Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-708. Repealed

Historical Note

R9-28-709. Repealed

Historical Note

R9-28-710. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-711. Repealed

Historical Note

R9-28-712. County of Fiscal Responsibility

A. General requirements.
1. The Administration shall determine the county of fiscal responsibility under A.R.S. § 36-2913 for an applicant or member who is elderly or physically disabled.
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7 and Article 11 of this Chapter.

B. Criteria for determining county of fiscal responsibility for an applicant.
1. If the applicant resides in the applicant’s own home, the county of fiscal responsibility is the county where the applicant currently resides.
2. This applies only if subsection (B)(3) does not apply. If the applicant is residing in a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant last resided in the applicant’s own home.
3. If the applicant moves from another state directly into a NF or alternative HCBS setting in this state, the county of fiscal responsibility is the county in which the person currently resides.
4. If the applicant moves from the Arizona State Hospital (ASH) into a NF or alternative HCBS setting, or is an inmate of a public institution moving from the public institution into a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant resided in the applicant’s own home prior to admission to ASH or the public institution.

C. Criteria for determining if there is a change in county of fiscal responsibility for a member moving from one county to another county.
1. No change in the county of fiscal responsibility. There is no change in the county of fiscal responsibility for a member if:
   a. The member moves from a NF to another NF in a different county,
   b. The member moves from a NF to an alternative HCBS setting in a different county,
   c. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
   d. The member moves from an alternative HCBS setting to a NF in a different county,
   e. The member moves from the member’s own home to an alternative HCBS setting in a different county,
   f. The member moves from the member’s own home to a NF in a different county,
   g. The member moves from a NF or alternative HCBS setting into ASH, or
   h. The member moves from ASH to a NF or alternative HCBS setting.
2. Change in the county of fiscal responsibility. If a member moves from one county to another, the county of fiscal responsibility changes to the new county if the member moves from:
   a. An alternative HCBS setting to the member’s own home in a different county,
   b. A NF to the member’s own home in a different county,
   c. The member’s own home to the member’s own home in a different county, or
   d. ASH to the member’s own home.
3. Transfers between program contractors. The county of fiscal responsibility changes if the Administration transfers a member from one program contractor to a different program contractor and if:
   a. Both program contractors agree, or
   b. The Administration determines that it is in the best interest of the member.

Historical Note

R9-28-713. Repealed

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 11 A.A.R. 3165, effective October 1, 2005 (Supp. 05-3). Section repealed by final rulemak-
A. A member is deceased, including but not limited to life estates and on an AHCCCS member's interest in any real property before the Purpose. The purpose of TEFRA is to allow AHCCCS to file a lien R9-28-801. TEFRA Liens – General

R9-28-801. Definitions Related to TEFRA Liens
In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definitions apply to this Article:

“Consecutive days” means days following one after the other without an interruption resulting from a discharge.

“File” means the date that AHCCCS receives a request for a State Fair Hearing under R9-28-805, as established by a date stamp on the request or other record of receipt.

“Home” means property in which a member has an ownership interest and that serves as the member's principal place of residence. This property includes the shelter in which a member resides, the land on which the shelter is located, and related outbuildings.

“Recover” means that AHCCCS takes action to collect from a claim.


B. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1010 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member's condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.

R9-28-803. TEFRA Liens – Prohibitions
AHCCCS shall not file a TEFRA lien against a member's home if one of the following individuals is lawfully residing in the member's home:

1. Member's spouse;
2. Member's child who is under the age of 21;
3. Member's child who is blind or disabled under 42 U.S.C. 1382c; or
4. Member's sibling who has an equity interest in the home

A. A rebuttable presumption exists that a member is permanently institutionalized if the member has continually resided in a nursing facility, ICF/MR, or other medical institution defined in 42 CFR 435.1010 for 90 or more consecutive days. A member may rebut the presumption by providing a written opinion from a treating physician, rendered to a reasonable degree of medical certainty, that the member's condition is likely to improve to the point that the member will be discharged from the medical institution and will be capable of returning home by a date certain.

R9-28-804. TEFRA Liens – AHCCCS Notice of Intent

A. Time-frame. At least 30 days before filing a TEFRA lien, AHCCCS shall send the member or member's representative a Notice of Intent.

B. Content of the Notice of Intent. The Notice of Intent shall include the following information:
1. A description of a TEFRA lien and the action that AHCCCS intends to take,
2. How a TEFRA lien affects a member's property,
3. The legal authority for filing a TEFRA lien,
4. The time-frames and procedures involved in filing a TEFRA lien, and
5. The member's right to request an exemption.

C. Request for exemption. A member or a member's representative may request an exemption. To request an exemption the member or the member's representative shall submit a written statement to AHCCCS within 30 days from the receipt of the Notice of Intent describing the factual basis for a claim that the property should be exempt from placement of a TEFRA lien or from recovery of lien based on R9-28-802, R9-28-803, or R9-
36-2932. Arizona long-term care system; powers and duties of the director; expenditure limitation

A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.

2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.

3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' requests for proposals for providers and provider subcontracts.

4. Providing technical assistance to the program contractors.

5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.

6. Conducting quality control on eligibility determinations and preadmission screenings.

7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.

8. Establishing an enrollment system.

9. Establishing a member case management tracking system.

10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.

11. Coordinating benefits as provided in section 36-2946.

12. Establishing standards for the coordination of services.

13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.

14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.

15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.

16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and posteligibility treatment of income pursuant to subsection L of this section.
17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.

18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall contract periodically as deemed necessary and as required by federal law for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules to specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules that provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

J. The director may apply for federal monies available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state monies appropriated for
the administration of the system may be used as matching monies to secure federal monies pursuant to this subsection.

K. The director shall adopt rules that establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources that determine the portion of a member's income that shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.

2. The maintenance needs of a spouse or family at home in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.

3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract that does not conform to federal requirements or that may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.

2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.
A. Subcontracts for services rendered by providers pursuant to section 36-2940 shall be awarded through competitive statewide proposals in as nearly the same manner as that provided in section 41-2534. If there is not a sufficient number of qualified proposals, a subcontract may be negotiated with a provider and shall be awarded pursuant to section 41-2536. In order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, the program contractor may negotiate and award without bid a provider subcontract if during the contract year there is an insufficient number of subcontracts awarded to providers. The term of the subcontract shall not extend beyond the next bid and subcontract award process as provided in this section, and the subcontract shall be at rates no greater than the weighted average rates for the appropriate level of care paid to similar providers in the same county. This section does not allow a program contractor to forego the competitive bid process pursuant to section 41-2534 unless there is an unanticipated increase in members enrolled in the system or a decrease in available beds brought about by the closure of a facility operated by a provider that is unable to be absorbed by current contracting providers located in the same general area. Before soliciting subcontracts without the competitive bid process, the program contractor shall receive approval from the director.

B. Hospitals that render care to members shall be paid by the program contractor as prescribed in section 36-2903.01, or such lower rate as may be negotiated by the program contractor.

C. The director may ensure through the subcontracts pursuant to subsection A of this section that at least ten per cent of the members are provided services pursuant to this article on a capitation basis.

D. A claim for an authorized service submitted by a licensed skilled nursing facility, an assisted living Arizona long-term care system provider or a home and community based Arizona long-term care system provider that renders care to members pursuant to this article shall be adjudicated within thirty calendar days after receipt by the program contractor. Any clean claim for an authorized service provided to a member that is not paid within thirty calendar days after the claim is received accrues interest at the rate of one per cent per month from the date the claim is submitted. The interest is prorated on a daily basis and must be paid by the program contractor at the time the clean claim is paid.
A. For each county that has a population of four hundred thousand persons or less according to the most recent United States decennial census and that was not approved as a program contractor before January 1, 1994 or that officially states that it wishes to end its status as a program contractor, the director at least every five years shall prepare and issue a request for proposal and a proposed contract format to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons to be a program contractor and provide services pursuant to this article on a capitation rate basis to members who are enrolled with the program contractors by the system, who are not persons with developmental disabilities as defined in section 36-551 and who are residents of the county at the time of application for the system.

B. The director may adopt rules regarding the request for proposal process which provide:

1. For the award of contracts by categories of members or services in order to secure the most financially advantageous proposals for the system.

2. That each qualified proposal shall be entered with separate categories for the distinct groups of members or services to be covered by the proposed contracts, as set forth in the request for proposal.

3. For the procurement of reinsurance for expenses incurred by any program contractor, any member or the system in providing services in excess of amounts specified by the director in any contract year.

4. For second round competitive proposals to request voluntary price reduction of proposals from only those proposals that have been tentatively selected for award, before the final award or rejection of proposals.

C. Contracts shall be awarded as otherwise provided by law, except that in no event may a contract be awarded to any program contractor which will cause the system to lose any federal monies to which it is otherwise entitled.

D. After contracts are awarded pursuant to this section, the director may negotiate with any successful proposal respondent for the expansion or contraction of services or service areas if there are unnecessary gaps or duplications in services or service areas.

E. Payments to program contractors pursuant to this section shall be made monthly or quarterly and may be subject to contract provisions requiring the retention of a specified percentage of the payment by the director, a reserve fund or other contract provisions by which adjustments to the payments are made based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. Reserve funds withheld from contracts shall be distributed to program contractors who meet performance standards established by the director. Any reserve fund established pursuant to this subsection shall be established as a separate account within the Arizona long-term care system fund.

F. Payments made pursuant to this section shall begin after a member is enrolled in the system.

G. Each program contractor pursuant to this section shall submit an annual audited financial and programmatic report for the preceding fiscal year as required by the administration. The report shall include beginning and ending fund balances, revenues and expenditures including specific identification of administrative costs. The report shall include the number of members served by the program contractor and the cost incurred for various types of services provided to members in a format prescribed by the director.

H. The director shall require contract terms necessary to ensure adequate performance by the program contractor of the provisions of each contract executed pursuant to this section. Contract provisions required by the director shall include the maintenance of deposits, performance bonds, financial reserves or other financial security.
36-2959. Reimbursement rates; capitation rates; annual review

A. The department shall contract with an independent consulting firm for an annual study of the adequacy and appropriateness of title XIX reimbursement rates to service providers for the persons with developmental disabilities program of both the Arizona long-term care system and the state only program. The consultant shall also include a recommendation for annual inflationary costs. Unless modified in response to federal or state law, the independent consulting firm shall include, in its recommendation, costs arising from amendments to existing contracts. The department may require, and the department's contracted providers shall provide, financial data to the department in the format prescribed by the department to assist in the study. A complete study of reimbursement rates shall be completed no less than once every five years.

B. Capitation rate adjustments shall be limited to utilization of existing services and inflation unless policy changes, including creation or expansion of programs, have been approved by the legislature or are specifically required by federal law or court mandate.

C. The administration shall contract with an independent consulting firm for an annual study of the adequacy and appropriateness of title XIX reimbursement rates to service providers for the elderly and physical disability program of the Arizona long-term care system. The administration may require, and the administration's contracted providers shall provide, financial data to the administration in the format prescribed by the administration to assist in the study. A complete study of reimbursement rates shall be completed no less than once every five years. In determining the adequacy of the rates in the five year study, the consulting firm shall examine in detail the costs associated with the delivery of services, including programmatic, administrative and indirect costs in providing services in rural and urban Arizona.

D. The department and the administration shall provide each of their reports to the joint legislative budget committee and the administration by October 1 of each year.

E. The department shall include the results of the study in its yearly capitation rate request to the administration.

F. If results of the study are not completely incorporated into the capitation rate, the administration shall provide a report to the joint legislative budget committee within thirty days of setting the final capitation rate, including reasons for differences between the rate and the study.
36-2999.51. Definitions

(Rpld. 10/1/23)

In this article, unless the context otherwise requires:

1. "Continuing care retirement community" means an entity that provides nursing facility services and assisted living or independent living services on a contiguous campus that is either registered as a life care facility with the department of insurance and financial institutions or has assisted living and independent living beds in the aggregate that equal at least twice the number of nursing facility beds. For the purposes of this paragraph, "contiguous" means land that adjoins or touches the other property held by the same or a related organization and land divided by a public road.

2. "Fiscal year" means the period beginning on October 1 and ending on September 30.

3. "Medicare resident days" means resident days that are funded by the medicare program, a medicare advantage or special needs plan or the medicare hospice program.

4. "Net patient service revenue" means gross inpatient revenues from services that are provided to nursing facility patients minus reductions from gross inpatient revenue. For the purposes of this paragraph, inpatient revenues from services do not include nonpatient care revenues such as beauty and barber income, vending income, interest and contributions, revenues from the sale of meals and all outpatient revenues.

5. "Nursing facility" means a health care institution that provides inpatient beds or resident beds and nursing services to persons who need nursing services on a continuing basis but who do not require hospital care or direct daily care from a physician. Nursing facility does not include the Arizona veterans' homes.

6. "Reductions from gross inpatient revenue" includes bad debts, contractual adjustments, uncompensated care, administrative, courtesy and policy discounts, adjustments and other similar revenue deductions.

7. "Resident day" means a calendar day of care provided to a nursing facility resident, including the day of admission and excluding the day of discharge. Resident day includes a day on which a bed is held for a patient and for which the facility receives compensation for holding the bed.

8. "Upper payment limit" means the limitation established pursuant to 42 Code of Federal Regulations section 447.272 that disallows federal matching funds if a state medicaid agency pays certain classes of nursing facilities an aggregate amount for services that would exceed the amount that would be paid for the same services furnished by that class of nursing facilities under medicare payment principles.
## AHCCCS Non-Emergency Medical Transportation

<table>
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<tr>
<th><strong>Contract language</strong></th>
<th><strong>Scope of Services</strong></th>
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<tbody>
<tr>
<td><strong>Transportation:</strong></td>
<td>These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member’s emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual (AMP) Policy 310-BB. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.</td>
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<tr>
<th><strong>Contract language</strong></th>
<th><strong>Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</strong></th>
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<td>The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (ACOM) Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.</td>
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The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met. |
**Contract language:** Subcontracts (NEMT Brokers are Administrative Services Subcontractors)

The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

<table>
<thead>
<tr>
<th>ACOM Policy 417, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</th>
<th>TRANSPORTATION TIMELINESS REVIEW</th>
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<tr>
<td>For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home.</td>
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<tr>
<td>The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.</td>
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<tr>
<th>ACOM Policy 417, Transportation Timeliness Deliverable format</th>
<th>Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs</th>
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<tr>
<td>Total Pickups, Timely Pickups, % of Timely Pickups</td>
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**Deliverable Data**

For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pickup trips were timely
### Strategy to Resolve NEMT Concerns: AHCCCS NEMT Workgroup

AHCCCS created an Internal NEMT workgroup which meets every six weeks. This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).

The Workgroup discusses concerns around NEMT services in general, as well as policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.

### Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers

MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.

One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides.
## Member Grievances and Quality of Care Concerns

<table>
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<tr>
<th>Contract Language:</th>
<th>Member Complaint/Grievance requirements</th>
<th>At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:</th>
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<td>The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.</td>
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<td>The Contractor shall address identified issues as expeditiously as the member’s condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].</td>
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<tr>
<td>Contract Language:</td>
<td>Quality Management and Quality of Care requirements</td>
<td>The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.</td>
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<td>The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].</td>
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<td>The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.</td>
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The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and **AMPM Policy 960**.

**AMPM Policy 960, Quality of Care Concerns**

The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in **AMPM Policy 961**. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.

...  
The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.  

a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor’s service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,  
b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor’s local QM Committee and local Medical Director, as Chairman of the QM Committee,  
c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,  
d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in ACOM Policy 407, ...
| AHCCCS Review of Quality of Care (QOC) cases | The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in AMPM Policy 960; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions. |
| AHCCCS Access to Care Committee | AHCCCS has an Access to Care Committee which meets quarterly. This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services. This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona. |
| **Contract Language:** Periodic Reporting Requirements | Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows:
1. **Timeliness:** Reports or other required data shall be received on or before scheduled due dates.
2. **Accuracy:** Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
3. **Completeness:** All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions. |

| **Contract Language:** Administrative Actions | Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, [ACOM Policy 408](https://example.com), [ACOM Policy 440](https://example.com), Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract. |
Background:
In the August 2, 2022 meeting of the Governor’s Regulatory Review Council (GRRC), in the discussion of AHCCCS’s 5 Year Review Report for rules in Title 9, Chapter 28, Articles 6 & 7, the Council requested further information be provided regarding AHCCCS’s oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) service. This document is to provide the Council with an update on the agency’s next steps in addressing the Council’s concerns, following internal workgroups and discussions with AHCCCS’s Managed Care Organizations (MCOs). Additionally, the attached document contains further information regarding AHCCCS’s existing contract and policy requirements that govern provision of NEMT services relevant to this request.

Due to the complicated nature of providing NEMT services that meet their members’ needs appropriately, State Medicaid Agencies often approach management and delivery of the NEMT benefit differently and with varying levels of success. States and other entities that administer NEMT benefits, including Medicaid MCOs and third-party transportation brokers, are engaged in a number of efforts to improve NEMT program administration, program integrity, and beneficiary experience. Arizona was recently highlighted in a Medicaid and CHIP Payment and Access Commission (MACPAC) June 2021 Report to Congress that covered some of these recurring issues with the provision of NEMT services, which highlighted AHCCCS’s efforts to be adaptive to member needs. AHCCCS maintains a standing internal NEMT workgroup to address concerns and be responsive to members’, MCOs’, and providers’ potential NEMT issues.

Updates:
The August 2, 2022 Council concerns and requests include the following:

● Raised specific concerns about how member grievances regarding NEMT are handled and how AHCCCS communicates the available options for grievances to members.
  ○ Information regarding member grievances is included in the attachment.

● Requested that AHCCCS share MCO contract requirements regarding NEMT, as well as information regarding how NEMT concerns are resolved.
  ○ AHCCCS MCO contract requirements for the provision of NEMT, and information regarding how NEMT concerns are resolved, are attached.

● Requested AHCCCS provide MCO contract requirements regarding quality assurance and quality of care concerns.
  ○ MCO quality assurance and quality of care contract requirements are detailed in the attachment.

● Requested information regarding how AHCCCS communicates NEMT services, and the different level or mobility issues covered by those services, to members.
  ○ AHCCCS MCO contract requirements relative to meeting the transportation needs of the member, and how AHCCCS communicates to members how they access NEMT, are attached.
AHCCCS is working with its NEMT Workgroup, and has reached out to its MCOs, to investigate and address the concerns raised by the Council. Thus far, the following actions have been taken:

- AHCCCS requested and received information from its MCOs regarding how the timeliness statistics for NEMT drop offs and pick-ups are calculated:
  - Numerator = Number of timely trips completed, where timely is defined as:
    - Drop-offs: No more than one hour before the medical appointment
    - Pick-ups: Member waiting no more than one hour after the end of treatment
    - These one hour limits are in accordance with AHCCCS Policy
  - Denominator = Total number of completed trips
- AHCCCS additionally requested information from its MCOs regarding the collection of canceled or rescheduled trips (not currently required by AHCCCS), to have the most complete picture possible of the member experience. The collection of this information is still in process.
- AHCCCS has communicated with MCOs to determine if they have a special designation/process for NEMT access to care for members with high health care needs (not currently required by AHCCCS). All MCOs confirmed that they do offer special assistance for high need members. AHCCCS learned that communication regarding how this service is handled is inconsistent among MCOs. For example, some MCOs put this information in their member handbooks, and some train case managers how to make this determination.

AHCCCS is examining the following strategies to address concerns surrounding NEMT:

- AHCCCS will add NEMT timeliness statistics to the Health Plan Report Card on the AHCCCS website so it is available to the public.
- AHCCCS is developing contract and policy language regarding MCOs tracking of provider cancellations/rescheduled trips and reporting the data to AHCCCS.
  - This data will be added to the Health Plan Report Card upon future receipt of the new deliverable.
- Based on the MCO feedback regarding the special assistance for members with high health care needs, AHCCCS intends to work with MCOs to standardize the high-need member designation across plans; and to develop, and consistently deliver, member communication regarding qualifications for, and how to request, such a designation from their MCO.
- AHCCCS has announced a grants program using funds generated by the American Rescue Plan (ARP) Act to expand, enhance and strengthen home and community based services (HCBS). This grant program should be available in mid-2023. It is AHCCCS’ hope that interested HCBS providers (including but not limited to assisted living facilities) would consider applying for grants to acquire vehicles to transport wheelchair utilizing and scooter-dependent resident members. Such activity would expand access to transportation services to the benefit of all members. When a qualified HCBS provider successfully applies to AHCCCS to add a transportation service to their provider profile, that provider would be paid for the provision of qualifying NEMT services. (Read more about the grants program in the AHCCCS ARPA HCBS Spending Plan on page 11.)
Finally, AHCCCS believes it is important to point out the significant number of NEMT services offered annually in order to offer some context around the NEMT statistics. In the attachment, AHCCCS reports six months of NEMT timeliness data for completed trips in contract year ending (CYE) 2022, from October 1, 2021 through March 31, 2022:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pick up trips were timely

It is important to note that, on an annualized basis, over 1.2 million drop offs will occur over the 12 months of CYE 2022, and over 1 million pickups. In total that is more than 2 million completed NEMT services in CYE 2022. While a 92% timeliness rate for drop off trips, and a 98% timeliness rate for pick ups, do convey high timeliness adherence, we will still expect to see approximately 120,000 member trips, and possibly an equal number of members impacted. These high numbers (despite the low percentages) can and do result in numerous complaints, and should not equate to an assumption of inaccuracy of the data.

**Attachment Information:**
The attachment contains relevant excerpts from AHCCCS CYE 2022 MCO contracts, the AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractor Operation Manual (ACOM).
## Non-Emergency Medical Transportation: AHCCCS Contract & Policy Requirements

<table>
<thead>
<tr>
<th><strong>AHCCCS Non-Emergency Medical Transportation Contract Language</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract language:</strong></td>
</tr>
<tr>
<td><strong>Scope of Services</strong></td>
</tr>
<tr>
<td>“Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member’s emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AHCCCS Medical Policy Manual (AMPM) Policy 310-BB. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.”</td>
</tr>
<tr>
<td><strong>Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</strong></td>
</tr>
<tr>
<td>“The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual (ACOM) Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment… The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.”</td>
</tr>
<tr>
<td><strong>Subcontracts</strong></td>
</tr>
<tr>
<td><em>(NEMT Brokers are Administrative Services Subcontractors)</em></td>
</tr>
<tr>
<td>“The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any...&quot;</td>
</tr>
</tbody>
</table>
subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables."

<table>
<thead>
<tr>
<th>ACOM 406, Member Handbook and Provider Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires that MCOs produce an annually updated member handbook, including language for members about how to obtain NEMT. The MCO must include in its handbook all information in ACOM 406, Attachment A. Attachment A includes: “How to Obtain Medically Necessary Transportation”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACOM Policy 417, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting</th>
</tr>
</thead>
</table>
| “G. Transportation Timeliness Review
For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home. The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.” |

<table>
<thead>
<tr>
<th>ACOM Policy 417, Transportation Timeliness Deliverable Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation Timeliness Deliverable Format:</td>
</tr>
<tr>
<td>● Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs</td>
</tr>
<tr>
<td>● Total Pickups, Timely Pickups, % of Timely Pickups</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliverable Data (Most recently available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:</td>
</tr>
<tr>
<td>● 92.50% of 638,948 total drop off trips were timely</td>
</tr>
<tr>
<td>● 98.05% of 570,725 total pickup trips were timely</td>
</tr>
<tr>
<td>Contract Language: Member Grievances and Quality of Care Concerns</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Contract Language:</strong> Member Complaint/Grievance requirements</td>
</tr>
<tr>
<td>“At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:</td>
</tr>
<tr>
<td>The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.</td>
</tr>
<tr>
<td>The Contractor shall address identified issues as expeditiously as the member’s condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].”</td>
</tr>
<tr>
<td><strong>Contract Language:</strong> Quality Management and Quality of Care requirements</td>
</tr>
<tr>
<td>The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.</td>
</tr>
<tr>
<td>The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].</td>
</tr>
<tr>
<td>The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.</td>
</tr>
<tr>
<td>The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality</td>
</tr>
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</table>
Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and **AMPM Policy 960**.

<table>
<thead>
<tr>
<th><strong>AMPM Policy 960</strong>, Quality of Care Concerns</th>
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</thead>
<tbody>
<tr>
<td>The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDMs), contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in <strong>AMPM Policy 961</strong>. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.</td>
</tr>
<tr>
<td>The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.</td>
</tr>
<tr>
<td>a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor’s service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,</td>
</tr>
<tr>
<td>b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor’s local QM Committee and local Medical Director, as Chairman of the QM Committee,</td>
</tr>
<tr>
<td>c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,</td>
</tr>
<tr>
<td>d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in <strong>ACOM Policy 407</strong>…”</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>AHCCCS Review of Quality of Care (QOC) Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is...</td>
</tr>
</tbody>
</table>
enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: [https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf)

MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in [AMPM Policy 960](https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf); MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.

| AHCCCS Access to Care Committee | AHCCCS has an Access to Care Committee which meets quarterly. This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.

This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona. |
<table>
<thead>
<tr>
<th>Additional Relevant Requirements/Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract Language:</strong> Periodic Reporting Requirements</td>
</tr>
<tr>
<td>Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions. Standards applied for determining adequacy of required reports are as follows:</td>
</tr>
<tr>
<td>1. <strong>Timeliness:</strong> Reports or other required data shall be received on or before scheduled due dates.</td>
</tr>
<tr>
<td>2. <strong>Accuracy:</strong> Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.</td>
</tr>
<tr>
<td>3. <strong>Completeness:</strong> All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions</td>
</tr>
<tr>
<td><strong>Contract Language:</strong> Administrative Actions</td>
</tr>
<tr>
<td>Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, ACOM Policy 408, ACOM Policy 440, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract.</td>
</tr>
<tr>
<td><strong>Strategy to Resolve NEMT Concerns:</strong> AHCCCS NEMT Workgroup</td>
</tr>
<tr>
<td>AHCCCS created an Internal NEMT workgroup which meets every six weeks. This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison). The Workgroup discusses concerns around NEMT services in general, as well as</td>
</tr>
<tr>
<td>Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers</td>
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<tr>
<td>policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.</td>
</tr>
</tbody>
</table>
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Title 9, Chapter 22, Articles 6, 7
GOVERNOR’S REGULATORY REVIEW COUNCIL
ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE:  June 1, 2022; July 6, 2022; August 2, 2022; September 7, 2022

TO:   Members of the Governor’s Regulatory Review Council (Council)

FROM:  Council Staff

DATE:  May 11, 2022

SUBJECT:  ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
Title 9, Chapter 22, Articles 6, 7

Summary

This Five-Year Review Report (5YRR) from the Arizona Health Care Cost Containment System (AHCCCS) relate to six (6) rules in Title 9, Chapter 22, Article 6 (RFP and Contract Process) and fifty-three (53) rules in Article 7 (Standards for Payments).

The rules in Article 6 relate to Request for Proposal (RFP) and contract process generally. Pursuant to A.R.S. § 36-2906, the director shall prepare and issue a request for proposal, including a proposed contract format, in each of the counties of this state, at least once every five years, to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons, including county-owned and operated health care facilities. The director shall adopt rules regarding the request for proposal process, which was done in Title 9, Chapter 22, Article 6. The rules in Article 7 relate to general standards for payments.

In the previous 5YRR for these rules, approved by the Council in November 2017, with regards to the rules in Article 7, AHCCCS indicated that it was "currently in the process of amending the [Diagnosis Related Group] rules to rebase the components of the DRG system using updated claims and encounter data" and would also "update the version of the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health..."
Information Systems for dates of discharge beginning January 1, 2018.” AHCCCS indicates it completed this proposed course of action by rulemaking subsequent to the prior 5YRR.

**Proposed Action**

As indicated in more detail below, AHCCCS intends to complete a rulemaking to address rules in Article 6 related to the RFP process that it believes are not currently effective in achieving their regulatory objectives and not enforced as written. AHCCCS indicates the proposed amendments are intended to: 1) Clarify the current RFP process wherein there are ambiguities, and 2) align AHCCCS’s process to best practice and other state procurement laws. AHCCCS indicates it will request a rulemaking exemption to make these changes within a month of this 5YRR being approved by the Council.

1. **Has the agency analyzed whether the rules are authorized by statute?**

   AHCCCS cites both general and specific authority for these rules.

2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**

   In the prior economic impact statement, AHCCCS stated that the amendments are primarily made to make the rules more clear, concise, and understandable. Minimal impact was anticipated. The small business community as a whole was not impacted by the clarifications. All affected entities benefit from the additional clarity and conciseness of the rule language. AHCCCS and contractors are also directly affected by and benefit from the clarifications.

   AHCCCS indicates there has been no noticeable change in the economic impact on small businesses or consumers of these regulations, in this case the offerors to the agency’s RFPs. This is because the prior rulemaking in 2012 enacted changes to streamline the RFP process for offerors. Since then, the rules have continued to operate as they were intended, are clear, concise, and understandable.

   The rule changes represent the most cost-effective and efficient method of fulfilling the agency’s responsibilities and impose only those requirements that are necessary to comply with federal law and state statute.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   For Article 6, AHCCCS believes the rules as written impose the least burden and cost when meeting their objectives. For Article 7, AHCCCS did not consider other alternatives because the changes are the most cost effective and efficient method of complying with federal law and state statute.

4. **Has the agency received any written criticisms of the rules over the last five years?**
AHCCCS indicates it has not received written criticisms of the rules in the last five years.

5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**

AHCCCS indicates the rules are clear, concise, and understandable.

6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**

AHCCCS indicates the rules are consistent with other rules and statutes.

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**

AHCCCS indicates the rules are generally effective in achieving their objectives. However, AHCCCS indicates rule R9-22-601 could be made more effective by amending the rule to remove the term “bids/offers” with “submitted proposals.”

8. **Has the agency analyzed the current enforcement status of the rules?**

AHCCCS indicates the rules are generally enforced as written except for the following rules:

- R9-22-602
- R9-22-603
- R9-22-604

The amendments AHCCCS proposes to make regarding these rules are outlined in Section 5 of the 5YRR.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

AHCCCS indicates the rules are not more stringent than corresponding federal law.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The rules do not require a permit, license, or agency authorization.

11. **Conclusion**

This 5YRR relates to six (6) rules in Title 9, Chapter 22, Article 6 (RFP and Contract Process) and fifty-three (53) rules in Article 7 (Standards for Payments). AHCCCS indicates the rules are generally clear, concise, understandable, consistent, effective, and enforced as written, except for rules R9-22-601 through 604. For those rules AHCCCS intends to amend to clarify the current RFP process wherein there are ambiguities and align AHCCCS’s process to best
practice and other state procurement laws. AHCCCS indicates it intends to request a rulemaking exemption to make these changes within a month of this 5YRR being approved by the Council.

Council staff recommends approval of this report.
practice and other state procurement laws. AHCCCS indicates it intends to request a rulemaking exemption to make these changes within a month of this 5YRR being approved by the Council.

Council staff recommends approval of this report.
January 28, 2022

**VIA EMAIL: grrc@azdoa.gov**

Nicole Sornsin, Chair  
Governor’s Regulatory Review Council  
100 North 15th Avenue, Suite 305  
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 22, Article 6, Five Year Review Report

Dear Ms. Sornsin:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 22, Article 6 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or nicole.fries@azahcccs.gov.

Sincerely,

Kasey Rogg  
Assistant Director

Attachments
1. **Authorization of the rule by existing statutes**

   General Statutory Authority: A.R.S. § 36-2903.01(F)
   Implementing statute: A.R.S. § 36-2906

2. **The objective of each rule:**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-22-601</td>
<td>The objective of this rule is to list the authority for the Request for Proposal (RFP) and describe the applicability of Article 6.</td>
</tr>
<tr>
<td>R9-22-602</td>
<td>The objective of this rule is to prescribe the contents of the RFP and the proposal process.</td>
</tr>
<tr>
<td>R9-22-603</td>
<td>The objective of this rule is to prescribe the process the Administration follows when awarding contracts.</td>
</tr>
<tr>
<td>R9-22-604</td>
<td>The objective of these rules is to prescribe the means of protesting an RFP or award including the administrative appeal process.</td>
</tr>
<tr>
<td>R9-22-605</td>
<td>The objective of this rule is to prescribe means by which an offeror or contractor may request from the Director a waiver of the requirement for hospital subcontracts.</td>
</tr>
<tr>
<td>R9-22-606</td>
<td>The objective of this rule is to prescribe sanctions the Director may impose on contractors for noncompliance and the factors considered when doing so.</td>
</tr>
</tbody>
</table>

3. **Are the rules effective in achieving their objectives?**

   Yes _X__  
   No __

   Except;

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-22-601</td>
<td>Replace bids/offers with submitted proposals</td>
</tr>
</tbody>
</table>

4. **Are the rules consistent with other rules and statutes?**

   Yes _X__  
   No __

5. **Are the rules enforced as written?**

   Yes _X__  
   No __

   Except;

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
</table>
   | R9-22-602    | Remove “The Administration shall not request best and final offers more than once unless the Administration determines that it is advantageous to the state to request additional best and final offers.” from subsection B(8) because ADOA (Arizona Department of Administration) has removed this language from their rules and AHCCCS would like to align with state best practices for procurement.  
   |              | Add “or other scope of work as applicable,” to subsection A(2).  
   |              | Add “or post such information publicly with the solicitation” to subsection B(1).  
   |              | Change and in subsection B(3) to and/or.  
   |              | Change proposal to RFP in subsection D                                         |
   | R9-22-603    | Update references to contract file to procurement file.                     |
Add “to an RFP” to subsection C.
Remove “or contract” from subsection C(2).
Add “3. The protest must be submitted to the procurement office by email unless otherwise allowed for in the RFP Instructions to Offerors.” to subsection C.
Change D to “Time for filing a RFP protest”.
Add “4. A protest is due by 5:00pm Arizona time on the due date. If the due date does not fall on a business day, the protest is due on the next business day.” to subsection D.
Add “Unless extended by a time period not to exceed 30 days under G(3)” to subsection G(1).
Add “electronic mail” to subsection G(2).
Change G(3) to read “The Administration may extend, for good cause, the time-limit for a decision in subsection (G)(1) by an additional time frame not to exceed 30 days. The procurement officer shall notify the protester in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.”

6. Are the rules clear, concise, and understandable?  
Yes _X__  No __

7. Has the agency received written criticisms of the rules within the last five years?  
Yes __  No _X_

8. Economic, small business, and consumer impact comparison:
There has been no noticeable change in economic impact on small businesses or consumers of these regulations, in this case the offerors to the agency’s RFPs (Request for Proposal). This is because the prior rulemaking in 2012 enacted changes to streamline the RFP process for offerors. Since then, the rules have continued to operate as they were intended, are clear, concise, and understandable. The changes recommended in this Five-Year Review Report have the same intention of streamlining the RFP process by updating the time for submissions and allowing correspondence, explicitly by e-mail, a practice already enacted by the agency. Therefore, the changes recommended in this report will have no economic impact on the agency or participants in the agency’s RFP process.

9. Has the agency received any business competitiveness analyses of the rules?  
Yes __  No _X_

10. Has the agency completed the course of action indicated in the agency’s previous five-year-review report?

11. A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:
The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. Are the rules more stringent than corresponding federal laws?  
Yes ___  No X

13. For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:
Not applicable.
14. **Proposed course of action:**

Following GRRC approval of this Five-Year Review Report, AHCCCS plans to undertake a workgroup with internal stakeholders in the RFP process to determine whether larger changes are made to the RFP process. Since any substantive changes to the RFP process could implicate the eligibility of contractors’ proposals, AHCCCS plans to undertake a regular rulemaking that allows for full participation by the public.
January 28, 2022

VIA EMAIL: grrc@azdoa.gov

Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: AHCCCS Title 9, Chapter 22, Article 7, Five Year Review Report

Dear Ms. Sornsin:

Please find enclosed the Five-Year Review Report of AHCCCS for Title 9, Chapter 22, Article 7 which is due on January 31, 2022.

AHCCCS hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Nicole Fries at 602-417-4232 or nicole.fries@azahcccs.gov.

Sincerely,

Kasey Rogg
Assistant Director

Attachments
1. **Authorization of the rule by existing statutes**

   General Statutory Authority: A.R.S. § 36-2903.01(F)
   Implementing statute: A.R.S. § 36-2906

2. **The objective of each rule:**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-22-701</td>
<td>The objective of this rule is to primarily provide definitions that specifically support the payment regulations outlined in Article 7.</td>
</tr>
<tr>
<td>R9-22-701.10</td>
<td>The objective of this rule is to describe the limitations on the scope of the liability for the Administration and contractors.</td>
</tr>
<tr>
<td>R9-22-702</td>
<td>The objective of this rule is to require health care providers to accept, as payment in full, the amount paid by the AHCCCS program plus any additional copayment or third-party payments made by or on behalf of the member. It also sets forth the circumstances when a member may be billed for services.</td>
</tr>
<tr>
<td>R9-22-703</td>
<td>The objective of this rule is to set forth claims submission timelines and related claims processing provisions required for reimbursement to providers for health care services.</td>
</tr>
<tr>
<td>R9-22-705</td>
<td>The objective of this rule is to describe payment guidelines for contracting prepaid health plans to reimburse subcontractors and non-contracting providers for the provision of health care services rendered to an AHCCCS member.</td>
</tr>
<tr>
<td>R9-22-708</td>
<td>The objective of this rule is to set forth provisions governing payment for services rendered to eligible American Indians.</td>
</tr>
<tr>
<td>R9-22-709</td>
<td>The objective of this rule is to describe provisions governing payment liability for emergency health care and subsequent care as well as facility transfer conditions.</td>
</tr>
<tr>
<td>R9-22-710</td>
<td>The objective of this rule is to describe provisions relating to fee schedules maintained by the Administration to reimburse non-hospital health care services.</td>
</tr>
<tr>
<td>R9-22-711</td>
<td>The objective of this rule is to describe the co-payment requirements that a member must pay when receiving medical services.</td>
</tr>
<tr>
<td>R9-22-712</td>
<td>The objective of this rule is to describe the cost-based reimbursement system that uses a prospective tiered per diem reimbursement methodology for inpatient services and a cost-to-charge ratio for outpatient services. The tiered per diem methodology includes: a statewide operating component, a blended statewide/hospital specific capital component and provisions for outlier payments; and provisions for transplant services and annual update factors.</td>
</tr>
<tr>
<td>R9-22-712.01</td>
<td>The objective of this rule is to describe the methodology for inpatient hospital reimbursement, explaining the tier rate data, components, assignment, and exclusions. In addition, it describes</td>
</tr>
</tbody>
</table>
when the tiers are updated and how new hospitals, outliers, transplants, ownership changes, psychiatric hospital specialty facilities and outliers for new hospitals are reimbursed.

<table>
<thead>
<tr>
<th>Rule Number</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R9-22-712.05</td>
<td>The objective of this rule is to describe how the Graduate Medical Education Fund will be allocated among hospitals.</td>
</tr>
<tr>
<td>R9-22-712.07</td>
<td>The objective of this rule is to describe how the Rural Hospital Inpatient Fund will be allocated among rural hospitals.</td>
</tr>
<tr>
<td>R9-22-712.09</td>
<td>The objective of this rule is to list the tier hierarchy of the inpatient reimbursement system.</td>
</tr>
<tr>
<td>R9-22-712.10</td>
<td>The objective of this rule is to describe general information applicable to the reimbursement of outpatient hospital services.</td>
</tr>
<tr>
<td>R9-22-712.15</td>
<td>The objective of this rule is to notify that reimbursement using the capped fee for service schedule is applicable to non-IHS acute hospitals.</td>
</tr>
<tr>
<td>R9-22-712.20</td>
<td>The objective of this rule is to describe the methodology for reimbursement using the capped fee for service schedule for outpatient hospital services.</td>
</tr>
<tr>
<td>R9-22-712.25</td>
<td>The objective of this rule is to describe how associated service costs are accounted for within the outpatient reimbursement methodology.</td>
</tr>
<tr>
<td>R9-22-712.30</td>
<td>The objective of this rule is to describe how reimbursement is made for a service not listed in the outpatient capped fee-for-service schedule.</td>
</tr>
<tr>
<td>R9-22-712.35</td>
<td>The objective of this rule is to describe how the outpatient capped fee for service schedule is adjusted by type of hospital submitting claims.</td>
</tr>
<tr>
<td>R9-22-712.40</td>
<td>The objective of this rule is to describe when updates are made to the outpatient fee schedule and rates used for reimbursement.</td>
</tr>
<tr>
<td>R9-22-712.45</td>
<td>The objective of this rule is to describe the reimbursement restrictions for outpatient hospital services.</td>
</tr>
<tr>
<td>R9-22-712.50</td>
<td>The objective of this rule is to describe the forms a hospital must use when billing for outpatient hospital services.</td>
</tr>
<tr>
<td>R9-22-712.60</td>
<td>The objective of this rule is to describe how the payments are made using the Diagnosis Related Group methodology.</td>
</tr>
<tr>
<td>R9-22-712.61</td>
<td>The objective of this rule explains the exceptions to the Diagnosis Related Group (DRG) methodology.</td>
</tr>
<tr>
<td>R9-22-712.62</td>
<td>The objective of this rule explains the calculation of the DRG base payment.</td>
</tr>
<tr>
<td>R9-22-712.63</td>
<td>The objective of this rule is to describe the calculation when the DRG base payment is not based on the statewide standardized amount.</td>
</tr>
<tr>
<td>R9-22-712.64</td>
<td>The objective of this rule sets forth the methodology for DRG base payments and the Outlier CCR (Cost-To-Charge Ratio) for out-of-state hospitals.</td>
</tr>
<tr>
<td>R9-22-712.65</td>
<td>The objective of this rule is to describe the DRG provider policy adjuster.</td>
</tr>
<tr>
<td>R9-22-712.66</td>
<td>The objective of this rule is to describe the DRG service policy adjuster.</td>
</tr>
<tr>
<td>R9-22-712.67</td>
<td>The objective of this rule explains the DRG reimbursement when there is a “transfer” of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children’s hospital, or a critical access hospital.</td>
</tr>
<tr>
<td>Rule</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>R9-22-712.68</td>
<td>The objective of this rule is to describe the DRG reimbursement when there is an unadjusted outlier add-on payment.</td>
</tr>
<tr>
<td>R9-22-712.69</td>
<td>The objective of this rule explains the DRG reimbursement when there is a covered day adjusted DRG base payment and covered day adjusted outlier add-on payment.</td>
</tr>
<tr>
<td>R9-22-712.70</td>
<td>The objective of this rule explains the DRG reimbursement when there is a covered day adjusted DRG payment and covered day adjusted outlier add-on payment for FES members.</td>
</tr>
<tr>
<td>R9-22-712.71</td>
<td>The objective of this rule describes the final DRG payment.</td>
</tr>
<tr>
<td>R9-22-712.72</td>
<td>The objective of this rule explains DRG reimbursement when there is an enrollment change during an inpatient stay.</td>
</tr>
<tr>
<td>R9-22-712.73</td>
<td>The objective of this rule explains DRG reimbursement for Inpatient stays for members eligible for Medicare.</td>
</tr>
<tr>
<td>R9-22-712.74</td>
<td>The objective of this rule describes DRG reimbursement when there is third party liability.</td>
</tr>
<tr>
<td>R9-22-712.75</td>
<td>The objective of this rule describes the payment for administrative days in relation to DRG reimbursement.</td>
</tr>
<tr>
<td>R9-22-712.76</td>
<td>The objective of this rule explains the reimbursement of interim claims in relation to DRG reimbursement.</td>
</tr>
<tr>
<td>R9-22-712.77</td>
<td>The objective of this rule describes DRG reimbursement when there are admissions and discharges on the same day.</td>
</tr>
<tr>
<td>R9-22-712.78</td>
<td>The objective of this rule explains DRG reimbursement when a member is readmitted to the hospital.</td>
</tr>
<tr>
<td>R9-22-712.79</td>
<td>The objective of this rule describes DRG reimbursement when there is a change in hospital’s ownership.</td>
</tr>
<tr>
<td>R9-22-712.80</td>
<td>The objective of this rule explains DRG reimbursement pertaining to new hospitals.</td>
</tr>
<tr>
<td>R9-22-712.81</td>
<td>The objective of this rule describes how the Administration handles updates to the DRG.</td>
</tr>
<tr>
<td>R9-22-712.90</td>
<td>The objective of this rule is to set forth reimbursement requirements for hospital-based freestanding emergency departments.</td>
</tr>
<tr>
<td>R9-22-713</td>
<td>The objective of this rule is to require a provider to repay overpayments to the Administration.</td>
</tr>
<tr>
<td>R9-22-714</td>
<td>The objective of this rule is to describe the requirement of a provider agreement and to set forth specific requirements for the Administration and a contractor to reimburse a provider.</td>
</tr>
<tr>
<td>R9-22-715</td>
<td>The objective of this rule is to describe basic contractor responsibilities relating to hospital negotiations. This subsection also enables the Administration to negotiate with hospitals on behalf of prepaid health plans for AHCCCS services.</td>
</tr>
<tr>
<td>R9-22-718</td>
<td>The objective of this rule is to require contractors to enter a contract for reimbursement of inpatient hospital services with one or more hospitals in a county of more than 500,000 individuals. This rule also delineates mandatory terms to be included in the contract.</td>
</tr>
<tr>
<td>R9-22-719</td>
<td>The objective of this rule is to allow the Administration to retain a specified percentage of capitation reimbursement to distribute monies to contractors based on their performance outcomes.</td>
</tr>
<tr>
<td>R9-22-720</td>
<td>The objective of this rule is to describe the reimbursement of reinsurance for high-cost hospital services.</td>
</tr>
</tbody>
</table>
The objective of this rule is to set forth the requirements for the hospital assessment levied against hospitals pursuant to ARS 36-2901.08.

3. **Are the rules effective in achieving their objectives?**
   - Yes _X__
   - No __

4. **Are the rules consistent with other rules and statutes?**
   - Yes _X__
   - No __

5. **Are the rules enforced as written?**
   - Yes _X__
   - No __

6. **Are the rules clear, concise, and understandable?**
   - Yes _X__
   - No __

7. **Has the agency received written criticisms of the rules within the last five years?**
   - Yes __
   - No _X_

8. **Economic, small business, and consumer impact comparison:**
   The rules in this article change often, some change annually. However much of the economic change, does not have a corresponding economic impact on the public because the costs are offset by legislative appropriations or federal-match funds made by the Center for Medicare and Medicaid Services. Economic differences between the programs outlined in these rulemakings can fluctuate annually based on several factors, which are outlined in each unique rulemaking. An example of these factors can be found in the Economic Impact Statement of the most recent rulemaking in this article, which has been attached to this 5YRR. However, for this article, there has not been a substantive economic impact since the last 5YRR.

9. **Has the agency received any business competitiveness analyses of the rules?**
   - Yes __
   - No _X_

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**
    Yes, the prior course of action has been implemented in successive rulemakings following the last 5YRR.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**
    The Administration believes the rules as written impose the least burden and cost when meeting their objectives.

12. **Are the rules more stringent than corresponding federal laws?**
    - Yes __
    - No X

13. **For rules adopted after July 29, 2010, that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**
    Not applicable.
14. **Proposed course of action:**

The agency did not recommend any changes to the article, therefore there is no proposed course of action.

**R9-22-525. Repealed**

**Historical Note**
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-525 adopted as an emergency adopted, amended and renumbered as Section R9-22-523, former Section R9-22-527 adopted as an emergency now adopted, amended and renumbered as Section R9-22-525 as a permanent rule effective August 30, 1982 (Supp. 82-4). Repealed effective October 1, 1985 (Supp. 85-5).

**R9-22-526. Renumbered**

**Historical Note**

**R9-22-527. Renumbered**

**Historical Note**

**R9-22-528. Renumbered**

**Historical Note**

**R9-22-529. Renumbered**

**Historical Note**
Adopted as Section R9-22-529 effective October 1, 1985, then renumbered as Section R9-22-1002 effective October 1, 1985 (Supp. 85-5).

**ARTICLE 6. RFP AND CONTRACT PROCESS**

**R9-22-601. General Provisions**

A. The Director has full operational authority to adopt rules for the RFP process and the award of contracts under A.R.S. § 36-2906.

B. This Article applies to the award of contracts under A.R.S. §§ 36-2904 and 36-2906 to provide services under A.R.S. § 36-2907 and the expenditure of public monies by the Administration pertaining to covered services when the procurement so states. The Administration shall establish conflict-of-interest safeguards for officers and employees of this state with responsibilities relating to contracts that comply with 42 U.S.C. 1396a-2(d)(3).

C. The Administration is exempt from the procurement code under A.R.S. § 41-2501.

D. The Administration and contractors shall retain all contract records for five years under A.R.S. § 36-2903 and dispose of the records under A.R.S. § 41-2550.

E. The following terms are defined as related to this Article:

“Procurement file” means the official records file of the Director whether located in the Office of the Director or at the public procurement unit. The procurement file shall include in electronic or paper form a list of notified vendors, final solicitation, solicitation amendments, bids/offers, final proposal revisions, clarifications, and final evaluation report.

**Historical Note**

**R9-22-602. RFP**

A. RFP content. The Administration shall include the following items in any RFP under this Article:

1. Instructions and information to an offeror concerning the proposal submission including:
   a. The deadline for submitting a proposal,
   b. The address of the office at which a proposal is to be received,
   c. The period during which the RFP remains open, and
   d. Any special instructions and information;

2. The scope of covered services under Article 2 of this Chapter and A.R.S. §§ 36-2906 and 36-2907, covered populations, geographic coverage, service and performance requirements, and a delivery or performance schedule;

3. The contract terms and conditions, including bonding or other security requirements, if applicable;

4. The factors used to evaluate a proposal;

5. The location and method of obtaining documents that are incorporated by reference in the RFP;

6. A requirement that the offeror acknowledge receipt of all RFP amendments issued by the Administration;

7. The type of contract to be used and a copy of a proposed contract form or provisions;

8. The length of the contract service;

9. A requirement for cost or pricing data; and

10. The minimum RFP requirements; and

11. A provision requiring an offeror to certify that a submitted proposal does not involve collusion or other anti-competitive practices.

B. Proposal process.

1. After the deadline for submitting proposals, the Administration may open a proposal publicly and announce and record the name of the offeror. The Administration shall keep all other information contained in a proposal confidential. The Administration shall open a proposal for public inspection after contract award unless the Administration determines that disclosure is not in the best interest of the state.

2. The Administration shall evaluate a proposal based on the GSA and the evaluation factors listed in the RFP.

3. The Administration may initiate discussions with a responsive and responsible offeror to clarify and assure full understanding of an offeror’s proposal. The Administration shall provide an offeror fair treatment with respect
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

The Administration shall award a contract to the responsible and responsive offeror whose proposal is determined most advantageous to the state under A.R.S. § 36-2906. If the Administration determines that multiple contracts are in the best interest of the state, the Administration may award multiple contracts. The contract file shall contain the basis on which the award is made.

Historical Note

R9-22-604. Contract or Proposal Protests; Appeals

A. Disputes related to contract performance. This Section does not apply to a dispute related to contract performance. A contract performance dispute is governed by 9 A.A.C. 34.

B. Resolution of a proposal protest. The procurement officer issuing a RFP shall have the authority to resolve proposal protests. An appeal from the decision of the procurement officer shall be made to the Director.

C. Filing of a protest.

1. A person may file a protest with the procurement officer regarding:
   a. A RFP issued by the Administration,
   b. A proposed award, or
   c. An award of a contract.

2. A protester shall submit a written protest and include the following information:
   a. The name, address, and telephone number of the protester;
   b. The signature of the protester or protester’s representative;
   c. Identification of a RFP or contract number;
   d. A detailed statement of the legal and factual grounds of the protest including copies of any relevant documents; and
   e. The relief requested.

D. Time for filing a protest.

1. A protester filing a protest alleging improprieties in an RFP or an amendment to an RFP shall file the protest at least 14 days before the due date of receipt of proposals.

2. Any protest alleging improprieties in an amendment issued 14 or fewer days before the due date of the proposal shall be filed before the due date for receipt of proposals.

3. In cases other than those covered in subsections (D)(1) and (2), a protester shall file a protest no later than 10 days after the procurement officer makes the procurement file available for public inspection.

E. Stay of procurement during the protest. If a protester files a protest before the contract award, the procurement officer may issue a written stay of the contract award. In considering whether to issue a written stay of contract, the procurement officer shall consider but is not limited to considering whether:

1. A reasonable probability exists that the protest will be sustained, and

2. The stay of the contract award is in the best interest of the state.
F. Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
1. An appeal is filed before a contract award, and
2. The procurement officer issues a stay of the contract award under subsection (E), unless
3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.

G. Decision by the procurement officer.
1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
2. The procurement officer shall furnish a copy of the decision to the protestor by:
   a. Certified mail, return receipt requested; or
   b. Any other method that provides evidence of receipt.
3. The Administration may extend, for good cause, the time limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protestor in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protestor may proceed as if the procurement officer issued an adverse decision.

H. Remedies.
1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
   a. Seriousness of the procurement deficiency;
   b. Degree of prejudice to other interested parties or to the integrity of the RFP process;
   c. Good faith of the parties;
   d. Extent of performance;
   e. Costs to the state, and
   f. Urgency of the procurement.
   g. Best interest of the state.
3. An appropriate remedy may include one or more of the following:
   a. Terminating the contract;
   b. Reissuing the RFP;
   c. Issuing a new RFP;
   d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
   e. Any relief determined necessary to ensure compliance with applicable statutes and rules.

I. Appeals to the Director.
1. A person may file an appeal of a procurement officer’s decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
2. The appeal shall contain:
   a. The information required in subsection (C)(2),
   b. A copy of the procurement officer’s decision,
   c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
   d. A request for hearing unless the person requests that the Director’s decision be based solely upon the procurement file.

J. Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
1. The appeal does not state a basis for protest,
2. The appeal is untimely under subsection (1)(1), or
3. The appeal is moot.

K. Hearing. Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

Historical Note

R9-22-605. Waiver of Contractor’s Subcontract with Hospitals
If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

Historical Note

R9-22-606. Contract Compliance Sanction
A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
2. Imposition of a monetary sanction.
B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 18 A.A.R. 2340, effective November 11, 2012 (Supp. 12-3).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:
“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is
F. Stay of contract award during an appeal to the Director. The Director shall automatically continue the stay of a contract award if:
   1. An appeal is filed before a contract award, and
   2. The procurement officer issues a stay of the contract award under subsection (E), unless
   3. The Director issues a written determination that the contract award is necessary to protect the best interest of the state.

G. Decision by the procurement officer.
   1. The procurement officer shall issue a written decision no later than 14 days after a protest has been filed. The decision shall contain an explanation of the basis of the decision.
   2. The procurement officer shall furnish a copy of the decision to the protested party by:
      a. Certified mail, return receipt requested; or
      b. Any other method that provides evidence of receipt.
   3. The Administration may extend, for good cause, the time-limit for decisions in subsection (G)(1) for a time not to exceed 30 days. The procurement officer shall notify the protesting party in writing that the time for the issuance of a decision has been extended and the date by which a decision shall be issued.
   4. If the procurement officer fails to issue a decision within the time-limits in subsection (G)(1) or (G)(3), the protesting party may proceed as if the procurement officer issued an adverse decision.

H. Remedies.
   1. If the procurement officer sustains the protest in whole or in part and determines that the RFP, proposed contract award, or contract award does not comply with applicable statutes and rules, the procurement officer shall order an appropriate remedy.
   2. In determining an appropriate remedy, the procurement officer shall consider all the circumstances of the procurement or proposed procurement, including:
      a. Seriousness of the procurement deficiency,
      b. Degree of prejudice to other interested parties or to the integrity of the RFP process,
      c. Good faith of the parties,
      d. Extent of performance,
      e. Costs to the state, and
      f. Urgency of the procurement.
      g. Best interest of the state.
   3. An appropriate remedy may include one or more of the following:
      a. Terminating the contract;
      b. Reissuing the RFP;
      c. Issuing a new RFP;
      d. Awarding a contract consistent with statutes, rules, and the terms of the RFP; or
      e. Any relief determined necessary to ensure compliance with applicable statutes and rules.

I. Appeals to the Director.
   1. A person may file an appeal of a procurement officer’s decision with both the Director and the procurement officer no later than five days from the date the decision is received. The date the decision is received shall be determined under subsection (G)(2).
   2. The appeal shall contain:
      a. The information required in subsection (C)(2),
      b. A copy of the procurement officer’s decision,
      c. The alleged factual or legal error in the decision of the procurement officer on which the appeal to the Director is based, and
      d. A request for hearing unless the person requests that the Director’s decision be based solely upon the procurement file.

J. Dismissal. The Director shall not schedule a hearing and shall dismiss an appeal with a written determination if:
   1. The appeal does not state a basis for protest,
   2. The appeal is untimely under subsection (I)(1), or
   3. The appeal is moot.

K. Hearing. Hearings under this Section shall be conducted using the Arizona Administrative Procedure Act under A.R.S. Title 41, Ch. 6.

R9-22-605. Waiver of Contractor’s Subcontract with Hospitals
If a contractor is unable to obtain a subcontract with a hospital as contractually required, the contractor may request in writing a waiver from the Administration as allowed by A.R.S. § 36-2906. The contractor shall state in the request the reasons a waiver is believed to be necessary and all efforts the contractor has made to secure a subcontract.

R9-22-606. Contract Compliance Sanction
A. The Director may impose sanctions upon a contractor for violation of any provision of this Chapter or of a contract. Sanctions include but are not limited to:
   1. Suspension of any or all further member enrollment, by choice and/or assignment for a period of time.
   2. Imposition of a monetary sanction.
B. The Director shall consider the nature, severity, and length of the violation when determining a sanction.
C. The Director shall provide a contractor with written notice specifying grounds and terms for the sanction.
D. Nothing contained in this Section shall be construed to prevent the Administration from imposing sanctions as provided in contract under A.R.S. § 36-2903.

R9-22-701. Standard for Payments Related Definitions
In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:
“Accommodation” means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is
semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

“Aggregate” means the combined amount of hospital payments for covered services provided within and outside the GSA.

“AHCCCS inpatient hospital day or days of care” means each day of an inpatient stay for a member beginning with the day of admission and including the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

“Ancillary service” means all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

“APC” means the Ambulatory Payment Classification system under 42 CFR 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

“Billed charges” means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

“Business agent” means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

“Capital costs” means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

“Copayment” means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

“Cost-to-charge ratio” (CCR) means a hospital’s costs for providing covered services divided by the hospital’s charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

“Covered charges” means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

“CPT” means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provide a uniform language to accurately designate medical, surgical, and diagnostic services.

“Critical Access Hospital” is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g). “Direct graduate medical education costs” or “direct program costs” means the costs that are incurred by a hospital for the education activities of an approved graduate medical education program that are the proximate result of training medical residents in the hospital, including resident salaries and fringe benefits, the portion of teaching physician salaries and fringe benefits that are related to the time spent in teaching and supervision of residents, and other related GME overhead costs.

“DRI inflation factor” means Global Insights Prospective Hospital Market Basket.

“Eligibility posting” means the date a member’s eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

“Encounter” means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

“Existing outpatient service” means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase or how the service was described in the charge master before filing the increase.

“Expansion funds” means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(G)(9)(b) and (c)(i).

“Factor” means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

“Fiscal intermediary” means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

“Freestanding Children’s Hospital” means a separately standing hospital with at least 12 pediatric beds that is dedicated to provide the majority of the hospital’s services to children.

“GME program approved by the Administration” or “approved GME program” means a graduate medical education program that has been approved by a national organization as described in 42 CFR 415.152.

“Graduate medical education (GME) program” means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

“HCAC” means a health care acquired condition described under 42 CFR 447.26 but does not include Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

“HCPCS” means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR 162, that establishes standards and requirements for the electronic transmission of certain health information by defining code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

“ICU” means the intensive care unit of a hospital.
“Indirect program costs” means the marginal increase in operating costs that a hospital experiences as a result of having an approved graduate medical education program and that is not accounted for by the hospital’s direct program costs.

“Intern and Resident Information System” means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

“Medical education costs” means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

“Medical review” means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

“Medicare Urban or Rural Cost-to-Charge Ratio (CCR)” means statewide average capital cost-to-charge ratio published annually by CMS added to the urban or rural statewide average operating cost-to-charge ratio published annually by CMS.

“National Standard code sets” means codes that are accepted nationally in accordance with federal requirements under 45 CFR 160 and 45 CFR 164.

“New hospital” means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial rate setting or rebasing.

“NICU” means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

“Non-IHS Acute Hospital” means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

“Observation day” means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient. Each observation day consists of a period of 24 hours or less.

“Operating costs” means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

“OPPC” means an Other Provider Preventable Condition that is: (1) a wrong surgical or other invasive procedure performed on a patient, (2) a surgical or other invasive procedure performed on the wrong body part, or (3) a surgical or other invasive procedure performed on the wrong patient.

“Organized health care delivery system” means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

“Outlier” means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(G).

“Outpatient hospital service” means a service provided in an outpatient hospital setting that does not result in an admission.

“Ownership change” means a change in a hospital’s owner, lessor, or operator under 42 CFR 489.18(a).

“Participating institution” means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

“Peer group” means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

“PPC” means prior period coverage. PPC is the period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, until the day a member is enrolled with a contractor.

“PPS bed” means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

“Procedure code” means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

“Prospective rates” means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

“Public hospital” means a hospital that is owned and operated by county, state, or hospital health care district.

“Qualifying health information exchange organization” means a non-profit health information organization as defined in A.R.S. § 36-3801 that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange. A qualifying health information exchange organization must include representation by the administration on its board of directors, and have a significant number of health care participants, including hospitals, laboratories, payers, community physicians and Federally Qualified Health Centers.

“Rebase” means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

“Reinsurance” means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

“Remittance advice” means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

“Resident” means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician’s eligibility for board certification.
“Revenue code” means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-04 forms.

“Sub-acute services” means inpatient care for a patient with an acute illness, injury or exacerbation of a disease process when the patient does not require acute inpatient hospitalization. Sub-acute care is rendered immediately after, or instead of, acute inpatient hospitalization.

“Specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

“Sponsoring institution” means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation.

“Tier” means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes, peer group, NICU classification level, or any combination of these items.

“Tiered per diem” means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

“Trip” means a one-way transport each time a taxi is called. If the taxi waits for the member then the transport continues to be part of the one-way trip. If the taxi leaves and is called to pick up the member, that is considered a new one-way trip.

**Historical Note**


R9-22-701.01. Reserved
R9-22-701.02. Reserved
R9-22-701.03. Reserved
R9-22-701.04. Reserved
R9-22-701.05. Reserved
R9-22-701.06. Reserved
R9-22-701.07. Reserved
R9-22-701.08. Reserved
R9-22-701.09. Reserved
R9-22-701.10 Scope of the Administration’s and Contractor’s Liability

The Administration shall bear no liability for providing covered services for any member beyond the date of termination of the member’s eligibility or during the member’s enrollment with a contractor. A contractor has no financial responsibility for services provided to a member beyond the last date of enrollment except as provided in Articles 2 and 5 of this Chapter and as specified in contract.

**Historical Note**

New Section made by final rulemaking at 13 A.A.R. 662, effective April 7, 2007 (Supp. 07-1).

R9-22-702. Charges to Members

A. For purposes of this subsection, the term “member” includes the member’s financially responsible representative as described under A.R.S. § 36-2903.01.

B. Registered providers must accept payment from the Administration or a contractor as payment in full.

C. Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.

D. An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:

1. To collect the copayment described in R9-22-711;
2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCS;
3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member’s AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member’s contractor is not responsible for payment of “out of network” services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member’s contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;

7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or

8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.

E. The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
   1. The member is unable or incompetent to sign such a document, or
   2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member’s health.

F. Except as provided for in this Section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider’s failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

Historical Note

R9-22-703. Payments by the Administration

A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of October 1, 2012, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

B. Timely submission of claims.
   1. Under A.R.S. § 36-2904, the Administration shall deem a paper claim to be submitted on the date that it is received by the Administration. An electronic claim is deemed received by the Administration when the claim enters the information processing system designated by the Administration for electronic claims in a form that is capable of being processed by the designated information processing system. The Administration shall do one or more of the following for each claim it receives:
      a. Place a date stamp on the face of the claim,
      b. Assign a system-generated claim reference number, or
      c. Assign a system-generated date-specific number.
   2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
      a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
      b. Six months from the date of eligibility posting.
   3. Unless a shorter time period is specified in contract, the Administration shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
      a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
      b. Twelve months from the date of eligibility posting.
   4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an HHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.

C. Claims processing.
   1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
   2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
      a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
      b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
      c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
   3. A claim is paid on the date indicated on the disbursement check.
   4. A claim is denied as of the date of the remittance advice.
   5. The Administration shall process a hospital claim under this Article.
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

a. Obtain prior authorization from the Administration for non-emergency hospital admissions, covered services as specified in Articles 2 and 12 of this Chapter, and for administrative days as described in R9-22-712.75.
b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
c. Make records available for review by the Administration upon request.

2. The Administration may deny a claim if the provider fails to comply with subsection (D)(1).

3. If the Administration issues prior authorization for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the Administration shall adjust the claim payment.

E. Review of claims and coverage for hospital supplies.
1. The Administration may conduct prepayment and post-payment review of any claims, including but not limited to hospital claims.
2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor or disposable razor,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Shampoo,
   l. Powder,
   m. Lotion,
   n. Comb, and
   o. Patient gown.

3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.

4. The Administration shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in Article 2;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.

5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.C. 34.

F. Overpayment for AHCCCS services.
1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
3. The Administration shall document any recoupment of an overpayment on a remittance advice.
4. An AHCCCS-registered provider may file a claim dispute under 9 A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.

G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

H. Prior quarter reimbursement. A provider shall:
1. Bill the Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from a member of AHCCCS eligibility.
2. Reimburse a member when payment has been received from the Administration for covered services during a prior quarter eligibility period. All funds paid by the member shall be reimbursed.
3. Accept payment received by the Administration as payment in full.

I. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.

J. Payment for out-of-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. The Administration shall reimburse an out-of-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).

K. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. The Administration shall reimburse an in-state or out-of-state provider of inpatient hospital services rendered with a discharge date on or after October 1, 2014, the DRG rate established by the Administration.

L. The Administration may enter into contracts for the provisions of transplant services.

Historical Note
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION


R9-22-704. Repealed

Historical Note

R9-22-705. Payments by Contractors

A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.

1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor as specified in this Article if:
   a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
   b. The service is emergent under Article 2 of this Chapter.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.

2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:

   a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
   b. Six months from the date of eligibility posting.

3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:

   a. Twelve months from the date of service or for an inpatient hospital claim, 12 months from the date of discharge; or
   b. Twelve months from the date of eligibility posting.

C. Date of claim.

1. A contractor’s date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.

2. A hospital claim is considered paid on the date indicated on the disbursement check.

3. A denied hospital claim is considered adjudicated on the date of the claim’s denial.

4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.

5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.

6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

D. Payment for in-state inpatient hospital services for claims with discharge dates on or before September 30, 2014. A contractor shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for Inpatient out-of-state hospital payments for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b).

F. Payment for inpatient hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

G. Payment for in-state outpatient hospital services.

A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005,
at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

H. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.

I. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45.

J. Review of claims and coverage for hospital supplies.
   1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
   2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor’s reasonable activities necessary to perform concurrent review and shall make the hospital’s medical records pertaining to a member enrolled with a contractor available for review.
   3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or postpayment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for an inpatient hospital admission, a specific service, or level of care but subsequent medical review indicates that the admission, the service, or level of care was not medically appropriate, the contractor shall adjust the claim payment.
   4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
   5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
      a. Patient care kit,
      b. Toothbrush,
      c. Toothpaste,
      d. Petroleum jelly,
      e. Deodorant,
      f. Septi soap,
      g. Razor,
      h. Shaving cream,
      i. Slippers,
      j. Mouthwash,
      k. Disposable razor,
      l. Shampoo,
      m. Powder,
      n. Lotion,
      o. Comb, and
      p. Patient gown.

6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.

7. The contractor shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-201;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.

8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

K. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration’s capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

L. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
   1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
   2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
   3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

M. Interest payment. In addition to the requirements in subsection (L), a contractor shall pay interest for late claims as defined by contract.

N. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-705 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of the

R9-22-706. Repealed

Historical Note

R9-22-707. Repealed

Historical Note

R9-22-708. Payments for Services Provided to Eligible American Indians

A. For purposes of this Article “IHS enrolled” or “enrolled with IHS” means an American Indian who has elected to receive covered services through IHS instead of a contractor.

B. For an American Indian who is enrolled with IHS, AHCCCS shall pay IHS the most recent all-inclusive inpatient, outpatient or ambulatory surgery rates published by Health and Human Services (IHS) in the Federal Register, or a separately contracted rate with IHS, for AHCCCS-covered services provided in an IHS facility. AHCCCS shall reimburse providers for the Medicare coinsurance and deductible amounts required to be paid by the Administration or contractor in Chapter 29, Article 3 of this Title.

C. When IHS refers an American Indian enrolled with IHS to a provider other than an IHS or tribal facility, the provider to whom the referral is made shall obtain prior authorization from AHCCCS for services as required under Articles 2, 7 or 12 of this Chapter.

D. For an American Indian enrolled with a contractor, AHCCCS shall pay the contractor a monthly capitation payment.

E. Once an American Indian enrolls with a contractor, AHCCCS shall not reimburse any provider other than IHS or a Tribal facility.

Historical Note

R9-22-709. Contractor’s Liability to Hospitals for the Provision of Emergency and Post-stabilization Care

A contractor is liable for emergency hospitalization and post-stabilization care as described in R9-22-210 and R9-22-210.01.
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

Historical Note

Editor’s Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-710. Payments for Non-hospital Services
A. Capped fee-for-service. The Administration shall provide notice of changes in methods and standards for setting payment rates for services in accordance with 42 CFR 447.205, December 19, 1983, incorporated by reference and on file with the Administration and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.

1. Non-contracted services. In the absence of a contract that specifies otherwise, a contractor shall reimburse a provider or noncontracting provider for non-hospital services according to the Administration’s capped-fee-for-service schedule.


a. A person shall submit an electronic claim consistent with 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).

b. A person shall submit a paper claim using the National Standard Code Sets as described under 45 CFR 160 (October 1, 2004) and 45 CFR 162 (October 1, 2004).

c. The Administration may deny a claim for failure to comply with subsection (A)(2)(a) or (b).

3. Fee schedule. The Administration shall pay providers, including noncontracting providers, at the lesser of billed charges or the capped fee-for-service rates specified in subsections (A)(3)(a) through (A)(3)(d) unless a different fee is specified in a contract between the Administration and the provider, or is otherwise required by law.

a. Physician services. Fee schedules for payment for physician services are on file at the central office of the Administration for reference use during customary business hours.

b. Dental services. Fee schedules for payment for dental services are on file at the central office of the Administration for reference use during customary business hours.

c. Transportation services. Fee schedules for payment for transportation services are on file at the central office of the Administration for reference use during customary business hours. For dates of service beginning:

i. October 1, 2012 through September 30, 2013, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2012.

ii. October 1, 2013 through September 30, 2014, the Administration and its contractors shall reimburse ambulance services at 68.59 percent of the ADHS rates that are in effect as of August 2, 2013.

iii. October 1, 2014 through September 30, 2015, the Administration and its contractors shall reimburse ambulance services at 74.74 percent of the ADHS rates that are in effect as of August 2, 2014.

d. Medical supplies and durable medical equipment (DME). Fee schedules for payment for medical supplies and DME are on file at the central office of the Administration for reference use during customary business hours. The Administration shall reimburse a provider once for purchase of DME during any two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless prior authorized by the Administration, no more than one repair and adjustment of DME shall be reimbursed during any two-year period.

B. Pharmacy services. The Administration shall not reimburse pharmacy services unless the services are provided by a pharmacy having a subcontract with a Pharmacy Benefit Manager (PBM) contracted with AHCCCS. Except as specifically in subsection (C), the Administration shall reimburse pharmacy services according to the terms of the contract.

C. FQHC Pharmacy reimbursement.

1. For purposes of this Section the following terms are defined:

a. “340B Drug Pricing Program” means the discount drug purchasing program described in 42 U.S.C 256b.

b. “340B Ceiling Price” means the maximum price that drug manufacturers can charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to HRSA.

c. “340B entity” means a covered entity, eligible to participate in the 340B Drug Pricing Program, as defined by the Health Resources and Human Services Administration.

d. “Actual Acquisition Cost (AAC)” means the purchase price of a drug paid by a pharmacy net of discounts, rebates, chargebacks and other adjustments to the price of the drug. The AAC excludes dispensing fees.
e. “Contracted Pharmacy” means an arrangement through which a 340B entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications subject to 340B pricing.

f. “Dispensing Fee” means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Dispensing Fee does not include any payment for the drugs being dispensed.

g. “Federally Qualified Health Center” means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the criteria under sections 1861(aa)(4) and 1905(i)(2)(B) of the Social Security Act and receives funds under section 330 of the Public Health Service Act.

h. “Federally Qualified Health Center Look-Alike” means a public or private non-profit health care organization that has been identified by HRSA and certified by CMS as meeting the definition of “health center” under section 330 of the Public Health Service Act, but does not receive grant funding under section 330.

i. “FQHC or FQHC Look-Alike pharmacy” means a pharmacy that dispenses drugs to FQHC or FQHC-LA patients and that is owned and/or operated by an FQHC/FQHC-LA or by an entity that reports the costs of an FQHC/FQHC-LA on its Medicare Cost Report, whether or not located with an FQHC or an FQHC Look-Alike.

2. Effective the later of February 1, 2012, or CMS approval of a State Plan Amendment, an FQHC or FQHC Look-Alike shall:

a. Notify the AHCCCS provider registration unit of its status as a 340B covered entity no later than:
   i. 30 days after the effective date of this Section;
   ii. 30 days after registration with the Health Resources and Services Administration (HRSA) for participation in the 340B program, or
   iii. The time of application to become an AHCCCS provider.

b. Provide the 340B pricing file to the AHCCCS Administration upon request. The 340B pricing file shall be provided in the file format as defined by AHCCCS.

c. Identify 340B drug claims submitted to the AHCCCS FFS PBMs or the Managed Care Contractors’ PBMs for reimbursement. The 340B drug claim identification and claims processing for a drug claim submission shall be consistent with claim instructions issued and required by AHCCCS to identify such claims.

3. The FQHC and the FQHC Look-Alike pharmacies shall submit claims for AHCCCS members for drugs that are identified in the 340B pricing file, whether or not purchased under the 340B pricing file, with the lesser of:
   a. The actual acquisition cost, or
   b. The 340B ceiling price.

4. The AHCCCS Fee-for-Service and Managed Care Contractors’ PBMs shall reimburse claims for drugs which are identified in the 340B pricing file dispensed by FQHC and FQHC Look-Alike pharmacies, whether or not purchased under the 340B pricing file, at the amount submitted under subsection (C)(3) plus a dispensing fee listed in the AHCCCS Capped Fee-For-Service Schedule unless a contract between the 340B entity and a Managed Care Contractor’s PBM specifies a different dispensing fee.

5. Contracted pharmacies shall not submit claims for drugs dispensed under an agreement with the 340B entity as part of the 340B drug pricing program, and the AHCCCS Administration and Managed Care Contractors shall not reimburse such claims.

6. The AHCCCS Administration and Managed Care Contractors shall reimburse contracted pharmacies for drugs not dispensed under an agreement with the 340B entity as part of the 340B program at the price and dispensing fee set forth in the contract between the contracted pharmacy and the AHCCCS or its Managed Care Contractors’ PBMs. Neither the Administration nor its Managed Care Contractors will reimburse a contracted pharmacy that does not have a contract with the Administration or MCO’s PBM.

7. The AHCCCS Administration and its Managed Care Contractors shall reimburse FQHC and FCHC Look-Alike pharmacies for drugs that are not eligible under the 340B Drug Pricing Program at the price and dispensing fee set forth in their contract with the AHCCCS or its Managed Care Contractors’ PBMs.

8. AHCCCS may periodically conduct audits to ensure compliance with this Section.

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-710 adopted as an emergency now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Amended as an emergency effective February 23, 1983, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-1). Amended as a permanent rule effective May 16, 1983; text of amended rule identical to emergency (Supp. 83-3). Former Section R9-22-710 repealed, new Section R9-22-710 adopted effective October 1, 1983 (Supp. 83-5). Amended effective October 1, 1985. The capped fee-for-service schedules, deleted from Section R9-22-710, are now on file at the central office of the Administration (Supp. 85-5).
2. An eligible individual is assigned to a hierarchy established in subsections (B) through (E), for the purposes of establishing a copayment amount.
3. No refunds shall be made for a retroactive period if there is a change in an individual’s status that alters the amount of a copayment.

B. The following services are exempt from AHCCCS copayments for all members:
1. Family planning services and supplies,
2. Services related to a pregnancy or any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for a pregnant woman,
3. Emergency services as described in 42 CFR 447.56(2)(i),
4. All services paid on a fee-for-service basis,
5. Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms,
6. Provider preventable services.

C. The following individuals are exempt from AHCCCS copayments:
1. An individual under age 19, including individuals eligible for the KidsCare Program in A.R.S. § 36-2982;
2. An individual determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. An individual eligible for the Arizona Long-Term Care Program in A.R.S. § 36-2931;
4. An individual eligible for QMB under Chapter 29;
5. An individual eligible for the Children’s Rehabilitative Services program under A.R.S. § 36-2906(E);
6. An individual receiving nursing facility or HCBS services under R9-22-216;
7. An individual receiving hospice care as defined in 42 U.S.C. 1396(o);
8. An American Indian individual enrolled in a health plan and has received services through an IHS facility, tribal 638 facility or urban Indian health program;
9. An individual eligible in the Breast and Cervical Cancer program as described under Article 20;
10. An individual who is pregnant and through the postpartum period following the pregnancy;
11. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age;
12. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age; and
13. An adult eligible under R9-22-1427(E), with income at or below 106% of the FPL.

D. Non-mandatory copayments. Unless otherwise listed in subsection (B) or (C), individuals under subsections (D)(1) through (6) are subject to the copayments listed in this subsection. A provider shall not deny a service when a member states to the provider an inability to pay a copayment.
1. A caretaker relative eligible under R9-22-1427(A);
2. An individual eligible for Young Adult Transitional Insurance (YATI) in A.R.S. § 36-2901(6a)(iii);
3. An individual eligible for State Adoption Assistance in R9-22-1433;
4. An individual eligible for Supplemental Security Income (SSI);
5. An individual eligible for SSI Medical Assistance Only (SSI/MAO) in Article 15; and
6. An individual eligible for the Freedom to Work program in A.R.S. § 36-2901(6g).
7. Copayment amount per service:
   a. $2.30 per prescription drug.
   b. $3.40 per outpatient visit, excluding an emergency room visit, if any of the services rendered during the visit are coded as evaluation and management services or non-emergent surgical procedures according to the National Standard Code Sets. An outpatient visit includes any setting where these services are performed such as a physician’s office, an Ambulatory Surgical Center (ASC), or a clinic.
   c. $2.30 per visit, if a copayment is not being imposed under subsection (D)(7)(b) and any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.

E. Mandatory copayments.
1. Copayments for individuals eligible for Transitional Medical Assistance (TMA) under R9-22-1427(B)(1)(c)(i). Unless otherwise listed in subsection (C), an individual is required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician’s provider’s office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
   a. $2.30 per prescription drug.
   b. $4.00 per outpatient visit, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
   c. If a copayment is not being imposed under subsection (E)(1)(b), $3.00 per visit if any of the services rendered during the visit are coded as physical, occupational or speech therapy services according to the National Standard Code Sets.
   d. If a copayment is not being imposed under subsection (E)(1)(b) or (c), $3.00 per visit, if any of the services rendered during the visit are coded as non-emergent surgical procedures according to the National Standard Code Sets.
2. Copayments for persons eligible under R9-22-1427(E) with income above 106% of the FPL and for persons eligible under A.R.S. §§ 36-2907.10 and 36-2907.11. Subject to CMS approval, unless otherwise listed in subsection (C), these individuals are required to pay the following copayments for prescription drugs and outpatient services unless the service is provided during an emergency room visit or the service is otherwise exempt under subsection (B). An outpatient visit includes any setting where these outpatient services are performed such as, an outpatient hospital, a physician’s provider’s office, HCBS setting, an Ambulatory Surgical Center (ASC), or a clinic:
   a. $4.00 per prescription drug.
   b. $5.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate from $50 to less than $100, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
   c. $10.00 per outpatient visit when the AHCCCS fee schedule for the visit code is a rate of $100 or greater, if any of the services rendered during the visit are coded as evaluation and management services according to the National Standard Code Sets.
   d. If a copayment is not being imposed under subsection (E)(2)(b) or (E)(2)(c), for services coded as
physical, occupational or speech therapy services according to the National Standard Code Sets.

i. $2.00 if the rate on the fee schedule is $20 to $39.99,

ii. $4.00 if the rate on the fee schedule is $40 to $49.99, or

iii. $5.00 if the rate on the fee schedule is $50 and above per visit.

e. If a copayment is not being imposed under subsection (E)(2)(b) – (E)(2)(d), for services coded as non-emergent surgical procedures according to the National Standard Code Sets,

i. $30.00 if the rate on the fee schedule is $300 to $499.99, or

ii. $50.00 if the rate on the fee schedule is $500 and above per visit.

f. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay $2.00 per trip for non-emergency transportation in an urban area.

g. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay $8.00 for non-emergency use of the emergency room.

h. Unless the individual is otherwise exempt in subsection (C) or the service is exempted under subsection (B) the individual is required to pay $75 for an Inpatient stay.

3. The provider may deny a service if the member does not pay the copayment required by subsection (E), however, a provider may choose to reduce or waive copayments under this subsection on a case-by-case basis.

F. A provider is responsible for collecting any copayment imposed under this Section.

G. The total aggregate amount of copayments under subsections (D) or (E) may not exceed 5% of the family’s income as applied on a quarterly basis. The member may establish that the aggregate limit has been met on a quarterly basis by providing the Administration with records of copayments incurred during the quarter. In addition, the Administration shall also use claims and encounters information available to the Administration to establish when a member’s copayment obligation has reached 5% of the family’s income.

H. Reduction in payments to providers. The Administration and its contractors shall reduce the payment it makes to any provider by the amount of a member’s copayment obligation under subsection (E), regardless of whether the provider successfully collects the copayments described in this Section.

Historical Note


Editor’s Note: The following Section was adopted and amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-712. Reimbursement: General

A. Inpatient and outpatient discounts and penalties. If a claim is denied for additional documentation required under A.R.S. § 36-2903.01(G)(4), the period during which the claim is denied is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(G)(5).

B. Inpatient and outpatient in-state or out-of-state hospital payments.

1. Payment for inpatient out-of-state hospital services for claims with discharge dates on or before September 30, 2014. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent statewide urban cost-to-charge ratio as determined in R9-22-712.01(6)(d).

2. Payment for inpatient in-state hospital services for claims with discharge dates on or before September 30, 2014. AHCCCS shall reimburse an in-state provider of inpatient hospital services rendered with a discharge date on or before September 30, 2014, at the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article.

3. Payment for inpatient in-state or out-of-state hospital services for claims with discharge dates on and after October 1, 2014 regardless of admission date. Subject to R9-22-718 and A.R.S. § 36-2905.01 regarding urban hospitals, a contractor shall reimburse an in-state or out-of-state provider of inpatient hospital services, at either a rate specified by subcontract or, in the absence of a subcontract, the DRG rate established by the Administration and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

4. Outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the statewide outpatient cost-to-charge ratio.
5. Outpatient in-state hospital payments. A contractor shall reimburse an in-state provider of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. The terms of the subcontract are subject to review and approval or disapproval under A.R.S. § 36-2904 and R9-22-715.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration’s designated representative in performance of the Administration’s utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. The Administration or contractor may deny a claim if a provider fails to obtain prior authorization as required under R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims.

F. Claim receipt.
1. The Administration’s date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.
3. A denied claim is considered adjudicated on the date the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.
1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital’s Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital’s Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than zero. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7%, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) by applying the following formula:
   CCR*[1.047*(1+% increase)]
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Where “CCR” means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (5) and “% increase” means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

“Charge master” means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

Historical Note


R9-22-712.01. Inpatient Hospital Reimbursement for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014

Inpatient hospital reimbursement. The Administration shall pay for covered inpatient acute care hospital services provided to eligible persons for claims with admission dates and discharge dates from October 1, 1998 through September 30, 2014, on a prospective reimbursement basis. The prospective rates represent payment in full, excluding quick-pay discounts, slow-pay penalties, and third-party payments for both accommodation and ancillary department services. The rates include reimbursement for operating and capital costs. The Administration shall make reimbursement for direct graduate medical education as described in A.R.S. § 36-2903.01. For payment purposes, the Administration shall classify each AHC-CCS inpatient hospital day of care into one of several tiers appropriate to the services rendered. The rate for a tier is referred to as the tiered per diem rate of reimbursement. The number of tiers is seven and the maximum number of tiers payable per continuous stay is two. Payment of outlier claims, transplant claims, or payment to out-of-state hospitals, freestanding psychiatric hospitals, and other specialty facilities may differ from the inpatient hospital tiered per diem rates of reimbursement described in this Section.

1. Tier rate data. The Administration shall base tiered per diem rates effective on and after October 1, 1998 on Medicare Cost Reports for Arizona hospitals for the fiscal year ending in 1996 and a database consisting of inpatient hospital claims and encounters for dates of service matching each hospital’s 1996 fiscal year end.

a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation, the Administration shall inflate all the costs to a common point in time as described in subsection (2) for each component of the tiered per diem rates. The Administration shall not make any changes to the tiered per diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than one hospital, the Administration shall allocate the costs to each of the respective hospitals. A hospital shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the database, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the database was developed for rates effective on and after October 1, 1998. The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude from the database or adjust claims and encounters that fail these edits. The Administration shall also exclude from the database the following claims and encounters:

i. Those missing information necessary for the rate calculation,

ii. Medicare crossovers,

iii. Those submitted by freestanding psychiatric hospitals, and

iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered per diem rate.

2. Tier rate components. The Administration shall establish inpatient hospital prospective tiered per diem rates based on the sum of the operating and capital components. The rate for the operating component is a statewide rate for each tier except for the NICU and Routine tiers, which are based on peer groups. The rate for the capital component is a blend of statewide and hospital-specific values, as described in A.R.S. § 36-2903.01. The Administration shall use the following methodologies to establish the rates for each of these components.

a. Operating component. Using the Medicare Cost Reports and the claim and encounter database, the Administration shall compute the rate for the operating component as follows:

i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary department cost-to-charge ratios and accommodation costs per day. To comply with 42 CFR 447.271, the Administration shall limit cost-to-charge ratios to 1.00 for each ancillary department.

ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter database for all hospitals. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the
departments in which the line items on the
Medicare Cost Reports are grouped. The ancillary department cost-to-charge ratios for a particular hospital are multiplied by the covered ancillary department charges on each of the hospital’s claims and encounters. The AHCCCS inpatient days of care on the particular hospital’s claims and encounters are multiplied by the corresponding accommodation costs per day from the hospital’s Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day do not include medical education and capital costs. The Administration shall inflate the resulting operating costs for the claims and encounters of each hospital to a common point in time, December 31, 1996, using the DRI inflation factor and shall reduce the operating costs for the hospital by an audit adjustment factor based on available national data and Arizona historical experience in adjustments to Medicare reimbursable costs. The Administration shall further inflate operating costs to the midpoint of the rate year (March 31, 1999).

iii. Operating cost tier assignment. After calculating the operating costs, the Administration shall assign the claims and encounters used in the calculation to tiers based on diagnosis, procedure, or revenue codes, or NICU classification level, or a combination of these. For the NICU tier, the Administration shall further assign claims and encounters to NICU Level II or NICU Level III peer groups, based on the hospital’s certification by the Arizona Perinatal Trust. For the Routine tier, the Administration shall further assign claims and encounters to the general acute care hospital or rehabilitation hospital peer groups, based on state licensure by the Department of Health Services. For claims and encounters assigned to more than one tier, the Administration shall allocate ancillary department costs to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (6).

iv. Operating rate calculation. The Administration shall set the rate for the operating component for each tier by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of AHCCCS inpatient hospital days of care reflected in the claim and encounter database for that tier.

b. Capital component. For rates effective October 1, 1999 the capital component is calculated as described in A.R.S. § 36-2903.01.

c. Statewide inpatient hospital cost-to-charge ratio. For dates of service prior to October 1, 2007, the statewide inpatient hospital cost-to-charge ratio is used for payment of outliers, as described in subsections (4), (5), and (6), and out-of-state hospitals, as described in R9-22-712(B). The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio by using the Medicare Cost Report data and claim and encounter database described in subsection (1) and used to determine the tiered per diem rates. For each hospital, the covered inpatient days of care on the claims and encounters are multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. Similarly, the covered ancillary department charges on the claims and encounters are multiplied by the ancillary department cost-to-charge ratios. The accommodation costs per day and the ancillary department cost-to-charge ratios for each hospital are determined in the same way described in subsection (2)(a) but include costs for operating and capital. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation costs and ancillary department costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for these services for all hospitals.

d. Unassigned tiered per diem rates. If a hospital has an insufficient number of claims to set a tiered per diem rate, the Administration shall pay that hospital the statewide average rate for that tier.

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure, or revenue codes, peer group, NICU classification level, or a combination of these.

a. Tier hierarchy. In assigning claims for AHCCCS inpatient hospital days of care to a tier, the Administration shall follow the Hierarchy for Tier Assignment through September 30, 2014 in R9-22-712.09. The Administration shall not pay a claim for inpatient hospital services unless the claim meets medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than two tiers, regardless of the number of interim claims that are submitted by the hospital.

b. Tier exclusions. The Administration shall not assign to a tier or pay AHCCCS inpatient hospital days of care that do not occur during a period when the person is eligible. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. The Administration shall pay same day admit and discharge claims that qualify for either the maternity or nursery tiers based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.

c. Seven tiers. The seven tiers are:

i. Maternity. The Administration shall identify the Maternity Tier by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the Administration shall pay the AHCCCS inpatient hospital days of care on the claim at the maternity tiered per diem rate.

ii. NICU. The Administration shall identify the NICU Tier by a revenue code. A hospital
does not qualify for the NICU tiered per diem rate unless the hospital is classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the NICU tier and have a NICU revenue code at the NICU tiered per diem rate. The Administration shall pay any remaining AHCCCS inpatient hospital day on the claim that does not meet NICU Level II or NICU Level III medical review criteria at the nursery tiered per diem rate.

iii. ICU. The Administration shall identify the ICU Tier by a revenue code. The Administration shall pay AHCCCS inpatient hospital days of care on the claim that meet the medical review criteria for the ICU tier and has an ICU revenue code at the ICU tiered per diem rate. The Administration may classify any AHCCCS inpatient hospital days on the claim without an ICU revenue code, as surgery, psychiatric, or routine tiers.

iv. Surgery. The Administration shall identify the Surgery Tier by a revenue code and a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list identifies minor procedures such as sutures that do not require the same hospital resources as other procedures. The Administration shall only split a surgery tier with an ICU tier. AHCCCS shall pay at the surgery tier rate only when the surgery occurs on a date during which the member is eligible.

v. Psychiatric. The Administration shall identify the Psychiatric Tier by either a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the psychiatric tier with any tier other than the ICU tier.

vi. Nursery. The Administration shall identify the Nursery Tier by a revenue code. The Administration shall not split a claim with AHCCCS inpatient hospital days of care in the nursery tier with any tier other than the NICU tier.

vii. Routine. The Administration shall identify the Routine Tier by revenue codes. The routine tier includes AHCCCS inpatient hospital days of care that are not classified in another tier or paid under any other provision of this Section. The Administration shall not split the routine tier with any tier other than the ICU tier.

4. Annual update. The Administration shall annually update the inpatient hospital tiered per diem rates through September 30, 2011.

5. New hospitals. For rates effective on and after October 1, 1998, the Administration shall pay new hospitals the statewide average rate for each tier, as appropriate. The Administration shall update new hospital tiered per diem rates through September 30, 2011.

6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers under this Section by multiplying the covered charges on a claim by the Medicare Urban or Rural Cost-to-Charge Ratio. The Urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more. The Rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

   a. Outlier criteria. For rates effective on and after October 1, 1998, the Administration set the statewide outlier cost threshold for each tier at the greater of three standard deviations from the statewide mean operating cost per day within the tier, or two standard deviations from the statewide mean operating cost per day across all the tiers. If the covered costs per day on a claim exceed the urban or rural cost threshold for a tier, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the applicable Medicare Urban or Rural CCR. The resulting amount will be the outlier payment. If there are two tiers on a claim, the Administration shall determine whether the claim is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying each tier rate by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital. Routine maternity stays shall be excluded from outlier reimbursement. A routine maternity stay is any one-day stay with a delivery of one or two babies. A routine maternity stay will be paid at tier.

   b. Update. The CCR is updated annually by the Administration for dates of service beginning October 1, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year. The Administration shall update the outlier cost thresholds for each hospital through September 30, 2011 as described under A.R.S. § 36-2903.01. For inpatient hospital admissions with begin dates of service on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.

   c. Medicare Cost-to-Charge Ratio Phase-In. AHCCCS shall phase in the use of the Medicare Urban or Rural Cost-to-Charge Ratios for outlier determination, calculation and payment. The three-year phase-in does not apply to out-of-state or new hospitals.

   i. Medicare Cost-to-Charge Ratio Phase-In outlier determination and threshold calculation. For outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. For outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient cost-to-charge ratio in effect on
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September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient cost-to-charge ratio and the effective Medicare Urban or Rural Cost-to-Charge Ratio. The adjusted hospital specific inpatient cost-to-charge ratios shall be used for all calculations using the Medicare Urban or Rural Cost-to-Charge Ratios, including outlier determination, and threshold calculation.

ii. Medicare Cost-to-Charge Ratio Phase-In calculation for payment. For payment of outlier claims with dates of service on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare Urban or rural cost-to-charge ratio. For payment of outlier claims with dates of service on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital cost-to-charge ratio in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital cost-to-charge ratio and the effective Medicare urban or rural cost-to-charge ratio.

iii. Medicare Cost-to-Charge Ratio for outlier determination, threshold calculation, and payment. For outlier claims with dates of service on or after October 1, 2009, the full Medicare Urban or Rural Cost-to-Charge Ratios shall be utilized for all outlier calculations.

d. Cost-to-Charge Ratio used for qualification and payment of outlier claims.

i. For qualification and payment of outlier claims with begin dates of service on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.

ii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011, the CCR will be equal to 90.25% of the most recent published Urban or Rural Medicare CCR as described in subsection (6)(b).

iii. For qualification and payment of outlier claims with begin dates of service on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.

iv. Subject to approval by CMS, for qualification and payment of outlier claims with begin dates of service on or after October 1, 2012, AHCCCS will reduce the cost-to-charge ratio determined under subsection (6)(d)(ii) for a hospital that filed a charge master with ADHS on or after June 1, 2012 by an additional percentage equal to the total percent increase reported on the charge master.

7. Transplants. The Administration shall reimburse hospitals for an AHCCCS inpatient stay in which a covered transplant as described in R9-22-206 is performed through the terms of the relevant contract. If the Administration and a hospital that performs transplant surgery on an eligible person do not have a contract for the transplant surgery, the Administration shall not reimburse the hospital more than what would have been paid to the contracted hospital for that same surgery.

8. Ownership change. The Administration shall not change any of the components of a hospital’s tiered per diem rates upon an ownership change.

9. Psychiatric hospitals. The Administration shall pay free-standing psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Department of Health Services.

10. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section as provided by A.R.S. § 36-2903.01. For purposes of this subsection, “specialty facility” means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

11. Outliers for new hospitals. Outliers for new hospitals will be calculated using the Medicare Urban or Rural Cost-to-Charge Ratio times covered charges. If the resulting cost is equal to or above the cost threshold, the claim will be paid at the Medicare Urban or Rural Cost-to-Charge ratio.

12. Reductions to tiered per diem payment for inpatient hospital services. Inpatient hospital admissions with begin dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the tiered per diem rates in effect on September 30, 2011.

Historical Note

R9-22-712.02. Reserved
R9-22-712.03. Reserved
R9-22-712.04. Reserved
R9-22-712.05. Graduate Medical Education Fund Allocation

A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(G)(9)(a).

B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under
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A.R.S. § 36-2903.01(G)(9)(b). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (B)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:
   a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
   b. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital’s Medicare Cost Report;
   c. It is not administered by or does not receive its primary funding from an agency of the federal government.

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (B)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):
   a. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(G)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
   b. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(G)(9)(a) that were established before July 1, 2006.

3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:
   a. A GME program shall provide all of the following:
      i. The program name and number assigned by the accrediting organization;
      ii. The original date of accreditation;
      iii. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
      iv. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
      v. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
   b. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
      i. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital’s two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
      ii. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital’s two most recently completed Medicare cost reporting years;
      iii. At the request of the Administration, a copy of the hospital’s Medicare Cost Report or any part of the report for the most recently completed cost reporting year.

4. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:
   a. Information provided by hospitals under subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (B)(3)(b)(i) and (ii).
   b. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined as follows:
      i. Total the number of days determined for each participating institution under subsection (B)(4)(a) and divide each total by 365.
      ii. Proportionally adjust the result of subsection (B)(4)(b)(i) for each participating institution within each program according to the number of residents determined to be eligible under subsection (B)(4)(c).
   c. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (B)(3) and the Administration’s inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (B)(3). The Medicaid-adjusted eligible residents shall be determined as follows:
      i. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
      ii. The number of allocated eligible residents determined for each participating hospital under subsection (B)(4)(b)(ii) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for that hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(i) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (B)(1)(c) shall be multiplied by the percentage derived under subsection (B)(4)(c)(i) for the program’s sponsoring institution or, if the sponsoring...
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institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated eligible residents determined under subsection (B)(4)(b)(ii) for a participating institution that is made ineligible under subsection (B)(1)(c) shall be multiplied by zero percent.

d. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (B)(4)(c)(ii) by the per-resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per-resident conversion factor shall be determined as follows:

i. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.

ii. Calculate the total allocated residents determined under subsection (B)(4)(b)(i) for those hospitals described under subsection (B)(4)(d)(i).

iii. Divide the total GME costs calculated under subsection (B)(4)(d)(i) by the total allocated residents calculated under subsection (B)(4)(d)(ii).

5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (B)(4) in the following manner:

a. The allocated amounts shall be distributed in the following order of priority:

i. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;

ii. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(G)(9)(a) for the direct costs of programs established before July 1, 2006;

b. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (B)(4)(c)(ii).

c. If funds are insufficient to cover all distributions within any priority group described under subsection (B)(5)(a), the Administration shall adjust the distributions proportionally within that priority group.

C. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(i). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (C)(3).

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (C) if it meets all the conditions of subsections (B)(1)(a) through (c).

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (C)(4), the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (B)(1)(c):

a. All filled resident positions in approved programs established on or after July 1, 2006; and

b. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (C)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.

3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (C) shall provide to the Administration:

a. A GME program shall provide all of the following:

i. The requirements of subsections (B)(3)(a)(i) through (iv);

ii. The academic year rotation schedule on file with the program current as of the date of reporting; and

iii. For programs described under subsection (C)(2)(b), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.

b. A hospital seeking a distribution under subsection (C) shall provide the requirements of subsection (B)(3)(b).

4. Allocation of expansion funds. Annually the Administration shall allocate available funds to approved GME programs in the following manner:

a. Information provided by hospitals in accordance with subsection (B)(3)(b) shall be used to determine the program in which each eligible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided in accordance with subsections (B)(3)(b)(i) and (ii).

b. For approved programs whose resident activity is not represented in the information provided in accordance with subsection (B)(3)(b), information provided by GME programs under subsection (C)(3)(a) shall be used to determine the number of days that each eligible resident is expected to work at each participating institution.

c. The number of eligible residents allocated to each participating institution for each approved GME program shall be determined by totaling the number of days determined under subsections (C)(4)(a) and (b) and dividing the totals by 365.

d. The number of allocated residents determined under subsection (C)(4)(c) shall be adjusted for Arizona Medicaid utilization in accordance with subsection (B)(4)(c).

e. The total allocation for each approved program shall be determined in accordance with subsection (B)(4)(d).

5. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (C)(4) to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible
residents allocated to each within that program under subsection (C)(4)(d).  

D. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for GME programs approved by the Administration to hospitals for indirect program costs eligible for funding under A.R.S. § 36-2903.01(G)(9)(c)(ii). A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (D)(3).  

1. Eligible health care facilities. A health care facility is eligible for distributions under subsection (D) if all of the following apply:  
   a. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona or is the base hospital for one or more of the GME programs in Arizona whose sponsoring institutions are not hospitals;  
   b. It incurs indirect program costs for the training of residents in the GME programs, which are or will be calculated on the hospital’s Medicare Cost Report or are reimbursable under the Children’s Hospitals Graduate Medical Education Payment Program administered by HRSA;  
   c. It is not administered by or does not receive its primary funding from an agency of the federal government.  

2. Eligible resident positions. For purposes of determining program allocation amounts under subsection (D)(4) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (D)(1)(c):  
   a. Any filled resident position in an approved program that includes a rotation of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule;  
   b. For approved programs that have been established for less than one year as of the date of reporting under subsection (D)(3) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match who will perform rotations of at least one month per year in a county other than Maricopa or Pima whose population was less than 500,000 persons at the time the residency rotation was added to the academic year rotation schedule.  

3. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (D) shall provide to the Administration:  
   a. A GME program shall provide all of the following:  
      i. The requirements of subsections (B)(3)(a)(i) through (iv);  
      ii. The academic year rotation schedule on file with the program current as of the date of reporting;  
      iii. For programs described under subsection (D)(2)(c), the number of residents expected to be enrolled as a result of the most recently completed annual resident match.  
   b. A hospital seeking a distribution under subsection (D) shall provide the requirements of subsection (B)(3)(b)(ii).  

4. Allocation of funds for indirect program costs. Annually the Administration shall allocate available funds to approved GME programs in the following manner:  
   a. Using the information provided by programs under subsection (D)(3), the Administration shall determine for each program the number of residents in the program who are eligible under subsection (D)(2) and the number of months per year that each eligible resident will perform rotations in counties described by subsection (D)(2), multiply the number of eligible residents by the number of months and multiply the result by the per resident per month conversion factor determined under subsection (D)(4)(b).  
   b. Using the most recent Medicare Cost Reports on file with the Administration for all hospitals that have calculated a Medicare indirect medical education payment, the Administration shall determine a per resident per month conversion factor as follows:  
      i. Calculate each hospital’s Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report by the total inpatient hospital discharges on the Medicare Cost Report.  
      ii. Calculate the ratio of patients to beds by dividing the total allocated residents described in subsection (B)(4)(d)(ii) by the number of bed days available from the Medicare Cost Report and dividing the result by the number of days in the cost reporting period.  
      iii. Calculate the indirect medical education adjustment factor by adding 1 to the value calculated in (D)(4)(b)(ii), multiplying the result by the exponential value 0.405, subtracting 1 from the result, and multiplying that result by 1.35.  
      iv. Calculate each hospital’s total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report, multiplying the total by the indirect medical education adjustment factor determined in (D)(4)(b)(iii) and dividing the result by the Medicare share determined in (D)(4)(b)(ii).  
      v. Calculate each hospital’s Medicaid indirect medical education cost by multiplying the amount determined in (D)(4)(b)(iv) by the value determined in subsection (B)(4)(c)(i).  
      vi. Total the amounts determined in (D)(4)(b)(v) for all hospitals, divide the result by the total allocated residents described in subsection (B)(4)(d)(ii) for all hospitals, and divide that result by 12.  

5. Distribution of funds for indirect program costs. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the amount calculated for the hospital at subsection (D)(4)(a).  

E. Reallocate of funds. If funds appropriated for subsection (B) are not allocated by the Administration and funds appropriated for subsections (C) and (D) are insufficient to cover all distri-
butions under subsections (C)(5) and (D)(5), the funds not allocated under subsection (B) shall be allocated under subsections (C) and (D) to the extent of the calculated distributions. If funds are insufficient to cover all distributions under subsections (C)(5) and (D)(5), the Administration shall adjust the distributions proportionally. If funds appropriated for subsections (C) and (D) are not allocated by the Administration and funds appropriated for subsection (B) are insufficient to cover all distributions under subsection (B)(5), the funds not allocated under subsections (C) and (D) shall be allocated under subsection (B) to the extent of the calculated distributions.

F. The Administration may enter into intergovernmental agreements with local, county, and tribal governments wherein local, county and tribal governments may transfer funds or certify public expenditures to the Administration. Such funds or certification, subject to approval by CMS, will be used to qualify for additional federal funds. Those funds will be used for the purposes of reimbursing hospitals that are eligible under subsection (D)(1) and specified by the local, county, or tribal government for indirect program costs other than those reimbursed under subsection (D). The Administration shall allocate available funds in accordance with subsection (D) except that reimbursement with such funds is not limited to resident positions or rotations in counties with populations of less than 500,000 persons. On an annual basis subject to available funds, the Administration shall distribute to each eligible hospital the greatest among the following amounts, less any amounts distributed under subsection (D)(5):

1. The amount that results from multiplying the total number of eligible residents allocated to the hospital under subsection (B)(4)(d)(ii) by 12 by the per resident per month conversion factor determined under subsection (D)(4)(b);
2. The amount calculated for the hospital at subsection (D)(4)(b)(v);
3. The median of all amounts calculated at subsection (D)(4)(b)(v) if the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a new training hospital; or
4. If the hospital does not have an indirect medical education payment calculated on the Medicare Cost Report because it is a children’s hospital, the median Medicaid indirect medical education payment costs shall be calculated as follows:
   a. For each hospital with indirect medical education costs on the Medicare Cost Report, determine a per resident total indirect medical education cost by dividing the total indirect medical education costs determined under subsection (D)(4)(b) by the number of filled resident positions under subsection (B)(2).
   b. Determine the median per resident amount under subsection (F)(4)(a).
   c. For each hospital without an indirect medical education component on the Medicare cost report, multiply the median per resident amount under subsection (F)(4)(b) by the number of filled resident positions under subsection (B)(2) for that hospital and by the Medicaid utilization percent for that hospital determined in subsection (B)(4)(c)(1).

Historical Note

R9-22-712.06. Reserved
R9-22-712.07. Rural Hospital Inpatient Fund Allocation
A. For purposes of this Section, the following words and phrases have the following meanings unless the context specifically requires another meaning:
1. “Calculated inpatient costs” means the sum of inpatient covered charges multiplied by the Milliman study’s implied cost-to-charge ratio of .8959.
2. “Claims paid amount” means the sum of all claims paid by the Administration and contractors, as reported by the contractor to the Administration, to a rural hospital for covered inpatient services rendered for dates of service during the previous state fiscal year.
3. “Fund” means any state funds appropriated by the Legislature for the purposes set forth in A.R.S. § 36-2905.02 and any federal funds that are available for matching the state funds.
4. “Inpatient covered charges” means the sum of all covered charges billed by a hospital to the Administration or contractors, as reported by the contractors to the Administration, for inpatient services rendered during the previous state fiscal year.
5. “Milliman study” means the report issued by Milliman USA on March 11, 2004, to the Arizona Hospital and Healthcare Association that updated a portion of a cost study entitled “Evaluation of the AHCCCS Inpatient Hospital Reimbursement System” prepared by Milliman USA for AHCCCS on November 15, 2002. A copy of each report is on file with the Administration.
6. “Rural hospital” means a health care institution that is licensed as an acute care hospital by the Arizona Department of Health Services for the previous state fiscal year and is not an IHS hospital or a tribally owned or operated facility and:
   a. Has 100 or fewer PPS beds, not including beds reported as sub provider beds on the hospital’s Medicare Cost Report, and is located in a county with a population of less than 500,000 persons, or
   b. Is designated as a critical access hospital for the majority of the previous state fiscal year.

B. Each February, the Administration shall allocate the Fund to the following three pools for the fiscal year:
1. Rural hospitals with 25 or fewer PPS beds not including sub provider beds and all Critical Access Hospitals, regardless of the number of beds in the Critical Access Hospital;
2. Rural hospitals other than Critical Access Hospitals with 26 to 75 PPS beds not including sub provider beds; and
3. Rural hospitals other than Critical Access Hospitals with 76 to 100 PPS beds not including sub provider beds.

C. The Administration shall allocate the Fund to each pool according to the ratio of claims paid amount for all hospitals assigned to the pool to total claims paid amount for all rural hospitals.

D. The Administration shall determine each hospital’s claims paid amount and allocate the funds in each pool to each hospital in the pool based on the ratio of each hospital’s claims paid amount to the sum of the claims paid amount for all hospitals assigned to the pool.

E. The Administration shall not make a Fund payment to a hospi
tal that will result in the hospital’s claims paid amount plus
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that hospital’s Fund payment being greater than that hospital’s calculated inpatient costs.
1. If a hospital’s claims paid amount plus the hospital’s Fund payment would be greater than the hospital’s calculated inpatient costs, the Administration shall make a Fund payment to the hospital equal to the difference between the hospital’s calculated inpatient costs and the hospital’s claims paid amount.
2. The Administration shall reallocate any portion of a hospital’s Fund allocation that is not paid to the hospital due to the reason in subsection (E)(1) to the other eligible hospitals in the pool based upon the ratio of the claims paid amount for each hospital remaining in the pool to the sum of the claims paid amount for each hospital remaining in the pool.
F. If funds remain in a pool after allocations to each hospital in the pool under subsections (D) and (E), the Administration shall reallocate the remaining funds to the other pools based upon the ratio of each pool’s original allocation of the Fund as determined under subsection (C) to the sum of the remaining pools’ original Fund allocations under subsection (C). The Administration shall allocate remaining funds to the hospitals in the remaining pools under subsection (D) and (E). See Exhibit 1 for an example.
G. Subject to CMS approval of the method and distribution of the Fund, the administration or its contractors will distribute the Fund as a lump sum allocation to the rural hospitals in either one or two installments by the end of each state fiscal year.

Historical Note
New Section made by final rulemaking at 12 A.A.R. 2188, effective June 6, 2006 (Supp. 06-2). Amended by final rulemaking at 22 A.A.R. 3476, effective January 30, 2016 (Supp. 15-4).

Historical Note

R9-22-712.10. Outpatient Hospital Reimbursement: General
A. Effective rule. The outpatient hospital reimbursement rules apply to dates of service beginning July 1, 2005, subject to Laws 2004, Ch. 279, § 19.
B. Basis For Payment. Except as provided under R9-22-712.30, AHCCCS shall pay for designated outpatient procedures provided to AHCCCS members according to the AHCCCS Outpatient Capped Fee-For-Service Schedule as defined in R9-22-712.20.
C. Data. AHCCCS shall use Medicare Cost Report and adjudicated claim and encounter data from non-IHS acute care hospitals located in the state of Arizona to develop fees for the AHCCCS Outpatient Capped Fee-For-Service Schedule.
D. Hospital Services Subject To Fees. AHCCCS shall reimburse services, in the following outpatient hospital categories under the AHCCCS Outpatient Capped Fee-For-Service Schedule:
1. Surgery,
2. Emergency Department,
3. Laboratory,
4. Radiology,
5. Clinic, and
6. Other services.
E. Reimbursement. AHCCCS shall reimburse outpatient hospital services by procedure codes, in proper combination with revenue codes, as prescribed by AHCCCS.

Historical Note
New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).
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R9-22-712.11. Reserved
R9-22-712.12. Reserved
R9-22-712.13. Reserved
R9-22-712.15. Outpatient Hospital Reimbursement: Affected Hospitals

Except as provided in R9-22-712(G), the AHCCCS Outpatient Capped Fee-For-Service Schedule shall apply to AHCCCS payments for outpatient services in all non-IHS acute hospitals.

Historical Note
New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.16. Reserved
R9-22-712.17. Reserved
R9-22-712.18. Reserved
R9-22-712.19. Reserved
R9-22-712.20. Outpatient Hospital Reimbursement: Methodology for the AHCCCS Outpatient Capped Fee-For-Service Schedule

A. To establish the AHCCCS Outpatient Capped Fee-for-service Schedule for all claims with a begin date of service on or before September 30, 2011, AHCCCS shall:

1. Define the dataset of claims and encounters that shall be used to establish the AHCCCS Outpatient Capped Fee-for-service Schedule.
2. Identify all the claims and encounters from non-IHS acute hospitals located in Arizona for services to be paid under the AHCCCS Outpatient Capped Fee-for-service Schedule.
3. Match the revenue code on each detail of each claim and encounter to the ancillary line itemCCR as reported on hospital-specific mapping documents and hospital-specific Medicare Cost Report for those hospitals that have submitted Medicare Cost Reports FYE 2002.
4. Multiply the line item CCR from subsection (A)(3) by the covered billed charge for that revenue code to establish the cost for the service.
5. Inflate the cost for the service from subsection (A)(4) using Global Insight Health-care Cost Review inflation factors from date of service month to the midpoint of the rate year in which the fees are initially effective.
6. Include associated costs under R9-22-712.25 to calculate the rates for emergency room and surgery services.
7. Combine data from all Arizona hospitals identified in subsection (A)(3) for each procedure code to establish the statewide median cost for each procedure.
8. Group procedure codes according to the Ambulatory Payment Classification (APC) System groups as listed in 69 FR 65682, November 15, 2004, and establish a statewide median cost for each APC. Multiply each statewide median APC cost by 116 percent to establish the AHCCCS-based fee for each procedure in that specific APC group. AHCCCS shall assign each procedure in the group the same fee.
9. For those procedure codes that are not grouped into any APC, establish a procedure-specific fee using either:
   a. The AHCCCS Non-hospital Capped Fee-for-service Fee Schedule,
   b. 116 percent of the procedure-specific median cost AHCCCS-based fee, or
   c. The Medicare Clinical Laboratory Fee Schedule for laboratory services.
10. Compare the AHCCCS-based fee established in subsections (A)(8) and (9) against the comparable Medicare fee established for the Medicare APC group as listed in the 69 FR 65682, November 15, 2004. The fee for each procedure shall be the greater of the AHCCCS-based fee or the Medicare fee but no more than 150 percent of the AHCCCS-based fee; however, for those laboratory services for which a limit is established in the Medicare Clinical Laboratory Fee Schedule, the fee shall not exceed that limit.
11. Assign the 2005 Medicare fee in the AHCCCS Outpatient Capped Fee-for-service Schedule for those procedures for which there are fewer than 20 occurrences of the procedure code in the dataset, either independently, or, if applicable, for all procedure codes within an APC Group.

B. For all claims with a begin date of service on or after October 1, 2011, the AHCCCS Outpatient Capped Fee-for-Service Schedule shall be derived from the CMS Medicare Outpatient Prospective Payment System (OPPS) fee schedule modified by an Arizona conversion factor determined annually.

1. When clinic services are billed using 51X revenue codes, the reimbursement to the hospital is the difference between the facility and non-facility rates payable to the practitioner for the procedures listed in the Administration’s Capped Fee-for-service Schedule under R9-22-710.
2. Observation services, when not billed in conjunction with a service for which a single payment is made under R9-22-712.25, are reimbursed at an hourly rate published in the Outpatient Capped Fee-for-service Schedule. This hourly rate includes reimbursement for associated services.
3. The AHCCCS Outpatient Capped Fee-for-service Schedule including the effective date of any changes to the listing are on file and posted on AHCCCS’ web site.

Historical Note

R9-22-712.21. Reserved
R9-22-712.22. Reserved
R9-22-712.23. Reserved
R9-22-712.24. Reserved
R9-22-712.25. Outpatient Hospital Fee Schedule Calculations: Associated Service Costs

A. AHCCCS shall include the costs of associated services, as defined by revenue codes and procedure codes, when determining the specific fees for the outpatient hospital procedures for emergency department and surgery services.
B. Payment made under subsection (A) or R9-22-712.20(B)(2) is inclusive of all services on the claim regardless of whether the services are provided on one or more days.
C. A complete listing of the revenue codes and procedure codes for associated costs included in the payment for emergency and surgery services including the effective date of any changes to the listing are on file and posted on AHCCCS’ web site.
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Historical Note
New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 17 A.A.R. 1460, effective October 1, 2011 (Supp. 11-3).

R9-22-712.26. Reserved
R9-22-712.27. Reserved
R9-22-712.28. Reserved
R9-22-712.29. Reserved
R9-22-712.30. Outpatient Hospital Reimbursement: Payment for a Service Not Listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule
A. AHCCCS shall calculate a statewide CCR for a service where a specific fee cannot be determined under R9-22-712.20.
B. For claims with a begin date of service on or before September 30, 2011, the statewide CCR shall be calculated based on the costs and covered charges associated with a service under subsection (A) for all Arizona hospitals, using the method specified in R9-22-712.20(A)(3).
C. For all claims with a begin date of service on or after October 1, 2011, the statewide CCR calculation shall equal either the CMS Medicare Outpatient Urban Cost-to-charge Ratio or the CMS Medicare Outpatient Rural Cost-to-charge Ratio published by CMS for the state of Arizona. AHCCCS shall use the urban cost-to-charge ratio for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. AHCCCS shall use the rural cost-to-charge ratio for hospitals located in a county of fewer than 500,000 residents. On October 1st of each year, AHCCCS shall adjust urban and rural CCRs to the CCRs as published by CMS in the Federal Register on or before August 1st of that year.
D. To determine the payment amount for procedures where a specific fee is not determined under R9-22-712.20, the statewide CCR is multiplied by the covered charges.
E. Reductions to payments for outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule. Outpatient hospital services not listed in the AHCCCS Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rate published by CMS pursuant to subsection (C) of this Section.

Historical Note

R9-22-712.31. Reserved
R9-22-712.32. Reserved
R9-22-712.33. Reserved
R9-22-712.34. Reserved
R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees
A. For all claims with a begin date of service on or before September 30, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
1. By 48 percent for public hospitals on July 1, 2005, and hospitals that were public anytime during the calendar year 2004;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
4. By 115 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the criteria during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective;
5. By 113 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital which is a hospital that has a majority of the members of its board of directors appointed by the Board of Regents during the contract year in which the Outpatient Capped Fee-for-service Schedule rates are effective.
B. For all claims with a begin date of service on or after October 1, 2011, AHCCCS shall increase the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services) for the following hospitals. A hospital shall receive an increase from only one of the following categories:
1. By 73 percent for public hospitals;
2. By 31 percent for hospitals in counties other than Maricopa and Pima with more than 100 licensed beds as of October 1 of that contract year;
3. By 37 percent for hospitals in counties other than Maricopa and Pima with 100 or fewer licensed beds as of October 1 of that contract year;
4. By 100 percent for hospitals designated as Critical Access Hospitals or hospitals that have not been designated as Critical Access Hospitals but meet the critical access criteria;
5. By 78 percent for a Freestanding Children’s Hospital with at least 110 pediatric beds as of October 1 of that contract year; or
6. By 41 percent for a University Affiliated Hospital, this is a hospital that has a majority of the members of its board of directors appointed by the Arizona Board of Regents.
C. In addition to subsections (A) and (B), an Arizona Level 1 trauma center as defined by R9-22-2101 shall receive a 50 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services and out-of-state hospital services) for Level 2 and 3 emergency department procedures.
D. Hospitals with greater than 100 pediatric beds not receiving an increase under subsection (B) shall receive an 18 percent increase to the Outpatient Capped Fee-for-service Schedule (except for laboratory services, and out-of-state hospital services).
E. For outpatient services with dates of service from October 1, 2020 through September 30, 2021, the payment otherwise required for outpatient hospital services provided by qualifying hospitals shall be increased by a percentage established by the administration. The percentage is published on the Administration’s public website as part of its fee schedule subsequent to the public notice published no later than September 1, 2020.
A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in (E)(1)(a), (b), (c), (d), or (e):
   a. By May 27, 2020, a hospital which did not receive Differential Adjusted Payments from October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:
      i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;
      ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department;
      iii. By August 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
      iv. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
      v. By September 1, 2020, or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
      vi. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;
      vii. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;
    viii. By November 1, 2020, the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to initiate and complete a Phase 1 data quality improvement effort, as defined by the qualifying HIE organization in collaboration with the qualifying HIE organization;
   ix. By January 1, 2021, the hospital must complete the Phase 1 initial data quality profile with a qualifying HIE organization;
   x. By May 1, 2021, the hospital must complete the Phase 1 final data quality profile with a qualifying HIE organization;
   b. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
      i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;
      ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
vi. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

vii. By November 1, 2020, the hospital must approve and authorize a formal SOW to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;

viii. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;

ix. By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;

x. Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:

1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data.

2. Meet a minimum performance standard of at least 60% based on March 2020 data.

3. If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria. Regardless of the percentage improvement from the baseline measurements;

c. Meet or exceed the statewide average on May 12, 2020 for the Severe Sepsis/Septic Shock (SEP-1) performance measure from the Medicare Hospital Compare website;

d. Be a participant in the Improving Pediatric Sepsis Outcomes collaborative in 2020;

e. For dates of services from October 1, 2020 through September 30, 2021, hospitals subject to APR-DRG reimbursement (Provider Type 02) may qualify for a DAP on codes J7296-J7298, J7300-J7301, and J7307 billed on the 1500 or UB-04 forms for long-acting reversible contraception devices.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

a. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

b. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

c. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

d. By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

e. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;

f. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

g. By November 1, 2020, the hospital must approve and authorize a formal SOW to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;

h. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;

i. By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;

j. Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:

i. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;

ii. Meet a minimum performance standard of at least 60% based on March 2020 data;

iii. If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements;

3. A hospital designated as type: hospital, subtype: long term, psychiatric, or rehabilitation by the Arizona Department of Health Services Division of Licensing Services will qualify for an increase if it meets the criteria specified in (E)(3)(a), (b), (c), (d), or (e):

a. By May 27, 2020, a hospital which did receive Differential Adjusted Payments from October 1, 2019 through September 30, 2020, submits a Letter of
Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department;

iii. By August 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

iv. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

v. By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

vi. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;

vii. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

viii. By November 1, 2020, the hospital must approve and authorize a formal SOW with a qualifying HIE organization to initiate and complete a Phase 1 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;

ix. By January 1, 2021, the hospital must complete the Phase 1 initial data quality profile with a qualifying HIE organization;

x. By May 1, 2021, the hospital must complete the Phase 1 final data quality profile with a qualifying HIE organization;

b. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
ment effort, as defined by the qualifying HIE organization and in collaboration with a qualifying HIE organization;

viii. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;

ix. By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;

x. Performance Criteria: Hospitals that meet each of the following HIE data quality performance criteria will be eligible to DAP increases;

(1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;

(2) Meet a minimum performance standard of at least 60% based on March 2020 data;

(3) If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

c. On May 12, 2020 is identified as a Medicare Annual Payment Update recipients on the QualityNet.org website;

d. On May 12, 2020 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Long Term Hospital Compare website;

e. On May 12, 2020 meets or falls below the national average for the rate of pressure ulcers that are new or worsened from the Medicare Inpatient Rehabilitation Facility Compare website.

4. A hospital designated as type: hospital by the Arizona Department of Health Services Division of Licensing Services and is owned and/or operated by Indian Health Services (HIS) or under Tribal authority will qualify for an increase if it meets this criteria. By May 27, 2020, a hospital submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

a. By May 27, 2020, the facility must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

b. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf;

c. By December 1, 2020, the facility must approve and authorize a formal SOW with a qualifying HIE organization to develop and implement the data exchange necessary to meet the requirements of Milestones d, e and f;

d. By April 1, 2021 the facility must electronically submit actual patient identifiable information to the production environment of a qualifying HIE organization, including admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department;

e. By June 1, 2021 the facility must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

f. If the facility has ambulatory and/or behavioral health practices, then no later than June 1, 2021 the facility must submit actual patient identifiable information to the production environment of a qualifying HIE, including registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization.

F. If a hospital submits a Letter of Intent to AHCCCS and received the Differential Adjusted Payments October 1, 2019 through September 30, 2020, but fails to achieve or maintain one or more of the required criteria by the specified date, that hospital will be ineligible to receive any Differential Adjusted Payments for dates of service from October 1, 2020 through September 30, 2021 if a Differential Adjusted Payment is available at that time.

G. Fee adjustments made under subsections (A), (B), (C), (D), and (E) are on file with AHCCCS and current adjustments are posted on AHCCCS’ website.

Historical Note


R9-22-712.36. Reserved

R9-22-712.37. Reserved

R9-22-712.38. Reserved

R9-22-712.39. Reserved

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add to the Outpatient Capped Fee-for-Service Schedule the new procedure codes for covered outpatient services and shall either assign the default CCR under R9-22-712.40(F)(2), the Medicare rate, or calculate an appropriate fee.
B. APC changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may choose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in the APC group.

C. Annual update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, through September 30, 2011, AHCCCS shall adjust outpatient fee schedule rates:
1. Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In a particular year the director may substitute the increases in subsection (C)(1) by calculating the dollar value associated with the inflation index in subsection (C)(1), and applying the dollar value to adjust rates at varying levels.

D. Reductions to the Outpatient Capped Fee-For-Service Schedule. Claims paid using the Outpatient Capped Fee-For-Service Schedule with dates of service on or after October 1, 2011, shall be reimbursed at 95 percent of the rates in effect on September 30, 2011, subject to the annual adjustments to procedure codes and APCs under this Section.

E. Rebase. AHCCCS shall rebase the outpatient fees every five years.

F. Statewide CCR:
1. For begin dates of service on or before September 30, 2011, the statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing. When rebasing, AHCCCS may recalculate the statewide CCR based on the costs and charges for services excluded from the outpatient hospital fee schedule.
2. For begin dates of service on or after October 1, 2011, the statewide CCR shall be set under R9-22-712.30(C).

G. Other Updates. In addition to the other updates provided for in this Section, the Administration may add the Outpatient Capped Fee-For-Service Fee Schedule and the Statewide CCR to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

**Historical Note**

R9-22-712.41. Reserved
R9-22-712.42. Reserved
R9-22-712.43. Reserved
R9-22-712.44. Reserved
R9-22-712.45. Outpatient Hospital Reimbursement: Outpatient Payment Restrictions

A. AHCCCS shall not reimburse hospitals for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis if the member is admitted as an inpatient to the same hospital directly from the emergency room, observation, or other outpatient department.

B. AHCCCS shall include payment for the emergency room, observation, and other outpatient hospital services provided to the member before the hospital admission in the AHCCCS Inpatient Tiered Per Diem Capped Fee-For-Service Schedule under Article 7 of this Chapter.

C. Same day admit and discharge.
1. For discharges before September 30, 2014. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital fee schedule.
2. For discharge dates on and after October 1, 2014. Same day admit and discharge claims are paid for through the outpatient fee schedule.

**Historical Note**
New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2). Amended by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.46. Reserved
R9-22-712.47. Reserved
R9-22-712.48. Reserved
R9-22-712.49. Reserved
R9-22-712.50. Outpatient Hospital Reimbursement: Billing

To receive appropriate reimbursement, hospitals shall:
1. Bill outpatient hospital services on the CMS approved Uniform Billing Form or in electronic format using the appropriate HIPAA transaction.
2. Follow the UB Manual Guidelines, as published by the National Uniform Billing Committee, and use the appropriate revenue code and procedure code combination as prescribed by AHCCCS and on file and online with AHCCCS.

**Historical Note**
New Section made by exempt rulemaking at 11 A.A.R. 2297, effective July 1, 2005 (Supp. 05-2).

R9-22-712.51. Reserved
R9-22-712.52. Reserved
R9-22-712.53. Reserved
R9-22-712.54. Reserved
R9-22-712.55. Reserved
R9-22-712.56. Reserved
R9-22-712.57. Reserved
R9-22-712.58. Reserved
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R9-22-712.59. Reserved

R9-22-712.60. Diagnosis Related Group Payments

A. Inpatient hospital services with discharge dates on or after October 1, 2014, shall be reimbursed using the diagnosis related group (DRG) payment methodology described in this Section and sections R9-22-712.61 through R9-22-712.81.

B. Payments made using the DRG methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately. Are reimbursed through the DRG methodology and not reimbursed separately.

C. Each claim for an inpatient hospital stay shall be assigned a DRG code and a DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. The applicable version of the APR-DRG classification system shall be available on the agency’s website.

D. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to quick pay discounts and slow pay penalties under A.R.S. 36-2904.

E. Payments for inpatient hospital services reimbursed using the DRG payment methodology are subject to the Urban Hospital Reimbursement Program under R9-22-718.

F. For purposes of this Section and sections R9-22-712.61 through R9-22-712.81:

1. “DRG National Average length of stay” means the national arithmetic mean length of stay published in the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems.

2. “Length of stay” means the total number of calendar days of an inpatient stay beginning with the date of admission through discharge, but not including the date of discharge (including the date of a discharge to another hospital, i.e., a transfer) unless the member expires.


4. “Medicare labor share” means a hospital’s labor costs as a percentage of its total costs as determined by CMS for purposes of the Medicare Inpatient Prospective Payment System.

Historical Note


R9-22-712.61. DRG Payments: Exceptions

A. Notwithstanding section R9-22-712.60, claims for inpatient services from the following hospitals shall be paid on a per diem basis, including provisions for outlier payments, where rates and outlier thresholds are included in the capped fee schedule published by the Administration on its website and available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The outlier CCR will be the sum of the urban or rural default operating CCR appropriate to the location of the hospital and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS. The resulting amount will be the total reimbursement for the claim. There is no provision for outlier payments for hospitals described under subsection (A)(3).

1. Hospitals designated as type: hospital, subtype: rehabilitation in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website in March of each year;

2. Hospitals designated as type: hospital, subtype: long term in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

3. Hospitals designated as type: hospital, subtype: psychiatric in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for March of each year;

B. Notwithstanding section R9-22-712.60, claims for inpatient services that are covered by a RBHA or TRBHA, where the principal diagnosis on the claim is a behavioral health diagnosis, shall be reimbursed as prescribed by a per diem rate described by a fee schedule established by the Administration; however, if the principal diagnosis is a physical health diagnosis, the claim shall be processed under the DRG methodology described in this section, even if behavioral health services are provided during the inpatient stay.

C. Notwithstanding section R9-22-712.60, claims for services associated with transplant services shall be paid in accordance with the contract between the AHCCCS administration and the transplant facility.

D. Notwithstanding section R9-22-712.60, claims from an IHS facility or 638 Tribal provider shall be paid the all-inclusive rate on a per visit basis in accordance with the rates published annually by IHS in the federal register.

E. For hospitals that have contracts with the Administration for the provision of transplant services, inpatient days associated with transplant services are paid in accordance with the terms of the contract.

F. For inpatient services with a date of admission from October 1, 2020 through September 30, 2021, provided by a hospital in subsection (A) that qualifies, the administration shall pay the hospital an Inpatient Differential Adjusted Payment equal to the sum of the payment otherwise provided for in subsection (A) plus the product of the amount otherwise provided for in subsection (A) and a percentage published on the Administration’s public website as part of its fee schedule, subsequent to a public notice published no later than September 1, 2020. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.

1. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in subsection (F)(1)(a), (i) through (x), (F)(1)(b), (i) through (x), and (1) through (3); (F)(1)(c); (F)(1)(d), or (F)(1)(e):

   a. By May 27, 2020, a hospital which did not receive Differential Adjusted Payments from October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:

      i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to
achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department;

iii. By August 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

iv. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

v. By September 1, 2020, or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

vi. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;

vii. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

viii. By November 1, 2020, the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to initiate and complete a Phase 1 data quality improvement effort, as defined by the qualifying HIE organization in collaboration with the qualifying HIE organization;

ix. By January 1, 2021, the hospital must complete the Phase 1 initial data quality profile with a qualifying HIE organization;

x. By May 1, 2021, the hospital must complete the Phase 1 final data quality profile with a qualifying HIE organization;

b. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;

ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

iii. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

iv. By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

v. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;

vi. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

vii. By November 1, 2020, the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization in collaboration with the qualifying HIE organization;

viii. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;
By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;

- Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:
  1. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;
  2. Meet a minimum performance standard of at least 60% based on March 2020 data;
  3. If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria.

Regardless of the percentage improvement from the baseline measurements;

c. Meet or exceed the statewide average on May 12, 2020 for the Severe Sepsis/Septic Shock (SEP-1) performance measure from the Medicare Hospital Compare website;

d. Be a participant in the Improving Pediatric Sepsis Outcomes collaborative in 2020;

e. For dates of services from October 1, 2020 through September 30, 2021, hospitals subject to APR-DRG reimbursement (Provider Type 02) may qualify for a DAP on codes J7296-J7298, J7300-J7301, and J7307 billed on the 1500 or UB-04 forms for long-acting reversible contraception devices.

2. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if it meets this criteria. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:

a. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain participation in the milestone activities if they have already been achieved;

b. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;

c. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

d. By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;

e. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;

f. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;

g. By November 1, 2020, the hospital must approve and authorize a formal SOW to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;

h. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;

i. By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;

j. Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:

i. Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;

ii. Meet a minimum performance standard of at least 60% based on March 2020 data;

iii. If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

Historical Note

R9-22-712.62. DRG Base Rate

A. The initial DRG base payment is the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code assigned to the claim, and any applicable provider and service policy adjustors.

B. The DRG base rate for each hospital is the statewide standardized amount of which the hospital’s labor-related share of that amount is adjusted by the hospital’s wage index. The hospital’s labor share is determined based on the labor share for the...
Medicare inpatient prospective payment system published in Volume 81 of the Federal Register at page 57312, published August 22, 2016. The hospital’s wage index is determined based on the wage index tables reference in Volume 81 of the Federal Register at page 57311 published August 22, 2016. The statewide standardized amount is included in the AHCCCS capped fee schedule available on the agency’s website.

C. Claims shall be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim (the “pre-HCAC" DRG code) and a DRG code derived excluding diagnosis and surgical procedure codes associated with the health care acquired conditions that were not present on admission or any other provider-preventable conditions (the “post-HCAC” DRG code). The DRG code with the lower relative weight shall be used to process claims using the DRG methodology.

Historical Note

R9-22-712.63. DRG Base Payments Not Based on the Statewide Standardized Amount
A. Notwithstanding Section R9-22-712.62, a select specialty hospital statewide standardized amount shall be used in place of the statewide standardized amount in subsection R9-22-712.62(B) to calculate the DRG base rate for the following hospitals:
1. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2011 Medicare Cost Report are reimbursed by Medicare.
2. Hospitals designated as type: hospital, subtype: short-term that has a license number beginning “SH” in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year.

B. The select specialty hospital standardized amount is included in the AHCCCS capped fee schedule available on the agency’s website.

Historical Note

R9-22-712.64. DRG Base Payments and Outlier CCR for Out-of-State Hospitals
A. DRG Base payment:
1. For high volume out-of-state hospitals defined in subsection (C), the wage adjusted DRG base payment is determined as described in R9-22-712.62.
2. Notwithstanding subsection R9-22-712.62 the wage adjusted DRG base rate for out-of-state hospitals that are not high volume hospitals shall be included in the AHCCCS capped fee schedule available on the agency’s website.

B. Outlier CCR:
1. Notwithstanding subsection R9-22-712.68, the CCR used for the outlier calculation for out-of-state hospitals that are not high volume hospitals shall be the sum of the statewide urban default operating cost-to-charge ratio and the statewide capital CCR in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.
2. The CCR used for the outlier calculation for high volume out-of-state hospitals is the same as in-state hospitals as described in R9-22-712.68.
3. A high volume out-of-state hospital is a hospital not otherwise excluded under R9-22-712.61, that is located in a county that borders the State of Arizona and had 500 or more AHCCCS covered inpatient days for the fiscal year beginning October 1, 2015.

D. Other than as required by this Section, DRG reimbursement for out-of-state hospitals is determined under R9-22-712.60 through R9-22-712.81.

Historical Note

R9-22-712.65. DRG Provider Policy Adjustor
A. After calculating the DRG base payment as required in sections R9-22-712.62, R9-22-712.63, or R9-22-712.64, for claims from a high-utilization hospital, the product of the DRG base rate and the DRG relative weight for the post-HCAC DRG code shall be multiplied by a provider policy adjustor that is included in the AHCCCS capped fee schedule available on the agency’s website.

B. A hospital is a high-utilization hospital if the hospital had:
1. Covered inpatient days subject to DRG reimbursement, determined using adjudicated claim and encounter data during the fiscal year beginning October 1, 2015, equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals;
2. A Medicaid inpatient utilization rate greater than 30% calculated as the ratio of AHCCCS-covered inpatient days to total inpatient days as reported in the hospital’s Medicare Cost Report for the fiscal year ending 2016; and,
3. Received less than $2 million in add-on payment for outliers under R9-22-712.68, based on adjudicated claims and encounters for fiscal year beginning October 1, 2015.

Historical Note

R9-22-712.66. DRG Service Policy Adjustor
In addition to Section R9-22-712.65, for claims with DRG codes in the following categories, the product of the DRG base rate, the DRG relative weight for the post-HCAC DRG code, and the DRG provider policy adjustor shall be multiplied by the service policy adjustor listed in the AHCCCS capped fee schedule, available on the agency’s website, corresponding to the following DRG codes:
1. Normal newborn DRG codes,
2. Neonates DRG codes,
3. Obstetrics DRG codes,
4. Psychiatric DRG codes,
5. Rehabilitation DRG codes,
6. Burn DRG codes,
7. Claims for members under age 19 assigned DRG codes other than listed above:
   a. For dates of discharge occurring on or after October 1, 2014 and ending no later than December 31, 2015 regardless of severity of illness level,
   b. For dates of discharge on or after January 1, 2016, for severity of illness levels 1 and 2,
c. For dates of discharge on or after January 1, 2016 and before January 1, 2017, for severity of illness levels 3 and 4.

d. For dates of discharge on or after January 1, 2017, and before January 1, 2018 for severity of illness levels 3 and 4.

e. For dates of discharge on or after January 1, 2018, for severity of illness levels 3 and 4.

8. Claims for members assigned DRG codes other than listed above.

Historical Note


R9-22-712.67. DRG Reimbursement: Transfers

A. For purposes of this Section a “transfer” means the transfer of a member from a hospital to a short-term general hospital for inpatient care, a designated cancer center, children’s hospital, or a critical access hospital except when a member is moved for the purpose of receiving sub-acute services.

B. Designated cancer center or children’s hospitals are those hospitals identified as such in the UB-04 billing manual published by the National Uniform Billing Committee.

C. The hospital the member is transferred from shall be reimbursed either the initial DRG base payment or the transfer DRG base payment, whichever is less.

D. The transfer DRG base payment is an amount equal to the initial DRG base payment, as determined after making any provider or service policy adjustments, divided by the DRG National Average length of stay for the DRG code multiplied by the sum of one plus the length of stay.

E. The hospital the member is transferred to shall be reimbursed under the DRG payment methodology without a reduction due to the transfer.

F. Unadjusted DRG base payment. The unadjusted DRG base payment is either the initial DRG base payment, as determined after making any provider or service policy adjustments, or the transfer DRG base payment, whichever is less.

Historical Note

New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3). Amended by final rulemaking at 22 A.A.R. 2187, effective October 1, 2016 (Supp. 16-4).

R9-22-712.68. DRG Reimbursement: Unadjusted Outlier Add-on Payment

A. Claims for inpatient hospital services qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold.

B. The claim cost is determined by multiplying covered charges by an outlier CCR as described by the following subsections:

1. For hospitals designated as type: hospital, subtype: children’s in the Provider & Facility Database for Arizona Medical Facilities posted by the ADHS Division of Licensing Services on its website for March of each year. The outlier CCR will be calculated by dividing the hospital total costs by the total charges using the most recent Medicare Cost Report available as of September 1 of that year.

2. For Critical Access Hospitals the outlier CCR will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio in the data file established as part of the Medicare Inpatient Prospective Payment System by CMS.

3. For all other hospitals the outlier CCR will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for each hospital in the impact file established as part of the Medicare Inpatient Prospective Payment System by CMS.

C. AHCCCS shall update the CCRs described in subsection (B) to conform to the most recent CCRs established by CMS as of September 1 of each year, and the CCRs so updated shall be used for claims with dates of discharge on or after October 1 of that year.

D. The outlier threshold is equal to the sum of the unadjusted DRG base payment plus the fixed loss amount. The fixed loss amount for critical access hospitals and for all other hospitals are included in the AHCCCS capped fee schedule available on the agency’s website.

E. For those inpatient hospital claims that qualify for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage for claims assigned DRG codes associated with the treatment of burns and for all other claims are included in the AHCCCS capped fee schedule available on the agency’s website.

Historical Note


R9-22-712.69. DRG Reimbursement: Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment

Adjustments to the payments are made to account for days not covered by AHCCCS as follows:

1. A covered day reduction factor unadjusted is determined if the member is not eligible on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay. In this case, a covered day reduction factor unadjusted is calculated by dividing the number of AHCCCS covered days by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.

2. A covered day reduction factor unadjusted is also determined if the member is eligible on the first day of the inpatient stay but is determined ineligible for one or more days prior to the date of discharge. In this case, a covered day reduction factor unadjusted is calculated by adding one to the number of AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of days the member is eligible during the inpatient stay.

3. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.

4. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.

5. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.
Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 1956 (Supp. 14-3).

R9-22-712.70. Covered Day Adjusted DRG Base Payment and Covered Day Adjusted Outlier Add-on Payment for FES members
In addition to the covered day reduction factor in R9-22-712.69, a covered day reduction factor unadjusted is determined for an inpatient stay during which an FES member receives services for the treatment of an emergency medical condition and also receives services once the condition no longer meets the criteria as an emergency medical condition described in R9-22-217.
1. A covered day reduction factor unadjusted is calculated by adding one to the AHCCCS covered days and dividing the result by the DRG National Average length of stay. The number of AHCCCS covered days is equal to the number of inpatient days during which an FES member receives services for an emergency medical condition as described in R9-22-217. For purposes of this adjustment, any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day.
2. If the covered day reduction factor unadjusted is greater than one, then the covered day reduction factor final is one; otherwise, the covered day reduction factor final is equal to the covered day reduction factor unadjusted.
3. The covered day adjusted DRG base payment is an amount equal to the product of the unadjusted DRG base payment and the covered day reduction factor final.
4. The covered day adjusted DRG outlier add-on payment is an amount equal to the product of the unadjusted DRG outlier add-on payment and the covered day reduction factor final.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.71. Final DRG Payment
The final DRG payment is the sum of the final DRG base payment, the final DRG outlier add-on payment, and the Differential Adjusted Payment.
1. The final DRG base payment is an amount equal to the product of the covered day adjusted DRG base payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
2. The final DRG outlier add-on payment is an amount equal to the product of the covered day adjusted DRG outlier add-on payment and a hospital-specific factor established to limit the financial impact to individual hospitals of the transition from the tiered per diem payment methodology and to account for improvements in documentation and coding that are expected as a result of the transition.
3. The factor for each hospital and for each federal fiscal year is published as part of the AHCCCS capped fee schedule and is available on the AHCCCS administration’s website and is on file for public inspection at the AHCCCS administration located at 701 E. Jefferson Street, Phoenix, Arizona.
4. For inpatient services with a date of discharge from October 1, 2020 through September 30, 2021, the Inpatient Differential Adjusted Payment is the sum of the final DRG base payment and the final DRG outlier add-on payment multiplied by a percentage published on the Administration’s public website as part of its fee schedule, subsequent to the public notice published no later than September 1, 2020. A hospital will qualify for an increase if it meets the criteria specified below for the applicable hospital subtype.
   a. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: short-term or children’s will qualify for an increase if it meets the criteria in (4)(a)(i), (1) through (10); (4)(a)(ii), (1) through (10)(a) through (c); and (4)(iii), (iv), or (v): i. By May 27, 2020, a hospital which did not receive Differential Adjusted Payments from October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying Health Information Exchange (HIE) organization in which the hospital agrees to achieve all of the following:
      (1) By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;
      (2) By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department;
      (3) By August 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
      (4) By September 1, 2020, electronically submit laboratory, radiology, transcription, and medication information, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination to a qualifying HIE or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if appli-
cable;
(5) By September 1, 2020, or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
(6) Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;
(7) By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;
(8) By November 1, 2020, the hospital must approve and authorize a formal scope of work (SOW) with a qualifying HIE organization to initiate and complete a Phase 1 data quality improvement effort, as defined by the qualifying HIE organization in collaboration with the qualifying HIE organization;
(9) By January 1, 2021, the hospital must complete the Phase 1 initial data quality profile with a qualifying HIE organization;
(10) By May 1, 2021, the hospital must complete the Phase 1 final data quality profile with a qualifying HIE organization;

ii. By May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
(1) By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;
(2) By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instruction, active medication, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
(3) By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
(4) By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
(5) Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;
(6) By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;
(7) By November 1, 2020, the hospital must approve and authorize a formal SOW to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;
(8) By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;
(9) By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;
(10) Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:
(a) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;
(b) Meet a minimum performance standard of at least 60% based on March 2020 data;
(c) If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria. Regardless of the percentage improvement from the baseline measurements;

iii. Meet or exceed the statewide average on May 12, 2020 for the Severe Sepsis/Septic Shock
(SEP-1) performance measure from the Medicare Hospital Compare website;
iv. Be a participant in the Improving Pediatric Sepsis Outcomes collaborative in 2020;
v. For dates of services from October 1, 2020 through September 30, 2021, hospitals subject to APR-DRG reimbursement (Provider Type 02) may qualify for a DAP on codes J7296-J7298, J7300-J7301, and J7307 billed on the 1500 or UB-04 forms for long-acting reversible contraception devices.
b. A hospital designated by the Arizona Department of Health Services Division of Licensing Services as type: hospital, subtype: critical access hospital will qualify for an increase if by May 27, 2020, a hospital which received Differential Adjusted Payments October 1, 2019 through September 30, 2020, submits a Letter of Intent to AHCCCS and a qualifying HIE organization in which the hospital agrees to achieve all of the following:
i. By May 27, 2020, the hospital must have in place an active participation agreement with a qualifying HIE organization and submit a LOI to AHCCCS and the HIE, in which it agrees to achieve the following milestones by the specified dates, or maintain its participation in the milestone activities if they have already been achieved;
ii. By June 1, 2020, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services), transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination;
iii. By September 1, 2020, or within 30 days of initiating COVID-19 lab testing, submit all COVID-19 lab test codes and the associated LOINC codes to qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
iv. By September 1, 2020 or within 30 days of initiating COVID-19 antibody testing, submit all COVID-19 antibody test codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of lab results within the HIE system if applicable;
v. Within 30 days of initiating COVID-19 immunizations, submit all COVID-19 immunization codes and the associated LOINC codes to the qualifying HIE to ensure proper processing of immunizations within the HIE system if applicable;
vi. By October 1, 2020, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf if applicable;
vii. By November 1, 2020, the hospital must approve and authorize a formal SOW to initiate and complete a Phase 2 data quality improvement effort, as defined by the qualifying HIE organization and in collaboration with the qualifying HIE organization;
viii. By January 1, 2021, the hospital must complete the Phase 2 initial data quality profile with a qualifying HIE organization;
ix. By May 1, 2021, the hospital must complete the Phase 2 final data quality profile with a qualifying HIE organization;
x. Hospitals that meet each of the following HIE data quality performance criteria will be eligible to receive DAP increases:
   (1) Demonstrate a 10% improvement from baseline measurements in the initial data quality profile, based on July 2019 data, to the final data quality profile, based on March 2020 data;
   (2) Meet a minimum performance standard of at least 60% based on March 2020 data;
   (3) If performance meets or exceeds an upper threshold of 90% based on March 2020 data the hospital meets the criteria, regardless of the percentage improvement from the baseline measurements.

Historical Note

R9-22-712.72. DRG Reimbursement: Enrollment Changes During an Inpatient Stay
A. If a member’s enrollment changes during an inpatient stay, including changing enrollment from fee-for-service to a contractor, or vice versa, or changing from one contractor to another contractor, the contractor with whom the member is enrolled on the date of discharge shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81. If the member is eligible but not enrolled with a contractor on the date of discharge, then the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay under the DRG payment rules in sections R9-22-712.60 through R9-22-712.81.
B. When a member’s enrollment changes during an inpatient stay, the hospital shall use the date of enrollment with the payer responsible on the date of discharge as the “from” date of service on the claim regardless of the date of admission.
C. Interim claims submitted to a payer other than the payer responsible on the day of discharge shall be processed in the
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ADMINISTRATION

R9-22-712.76. DRG Reimbursement: Interim Claims

A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.

B. Hospitals shall be reimbursed for interim claims at a per diem rate of $500 per day.

C. Following discharge, the hospital shall void all interim claims.

In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

Historical Note

R9-22-712.77. DRG Reimbursement: Admissions and Discharges on the Same Day

A. Except as provided for in subsection (B), for any claim for inpatient services with an admission date and discharge date that are the same calendar date, the contractor or the Administration shall process the claim as an outpatient claim and the hospital shall be reimbursed under R9-22-712.10 through R9-22-712.50.

B. Claims with an admission date and discharge date that are the same calendar date that also indicate that the member expired not transferred or discharged the member because of the hospital’s administrative or operational delays.

c. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).

2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.

B. Reimbursement of Administrative Days.

1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.

2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the criteria of “Service Description – Psychiatric Stay,” regardless of revenue code.

C. Prior authorization is required for administrative days.

D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

Historical Note

same manner as other interim claims as described in R9-22-712.76.

Historical Note

R9-22-712.73. DRG Reimbursement: Inpatient Stays for Members Eligible for Medicare

If the hospital receives less than the full Medicare payment for a member eligible for benefits under Part A of Medicare because the member has exceeded the maximum benefit permitted under Part A of Medicare, the hospital shall submit a separate claim for services performed after the date the maximum Medicare Part A benefit is exceeded. The claim may include all diagnosis codes for the entire inpatient stay, but the hospital is only required to include revenue codes, surgical procedure codes, service units, and charges for services performed after the date the Medicare Part A benefit is exceeded. A claim so submitted shall be reimbursed using the DRG payment methodology.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.74. DRG Reimbursement: Third Party Liability

DRG payments are subject to reduction based on cost avoidance under Section R9-22-1003 and other rules regarding first-and third-party liability under Article 10 of this Chapter including cost avoidance for claims for ancillary services covered under Part B of Medicare.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.75. DRG Reimbursement: Payment for Administrative Days

A. Categories of Administrative Days. Administrative days fall into one of two categories, either subsection (A)(1) or (A)(2).

1. Administrative days due to lack of appropriate placement options and not meeting inpatient medical criteria. Administrative days are days in which a member is admitted as an inpatient to an acute care hospital, does not meet the criteria for an acute inpatient stay, but is admitted or not discharged because: (1) an appropriate placement outside the hospital is not available, (2) the member cannot be safely discharged or transferred, or (3) the Administration or the contractor failed to provide for the appropriate placement outside the hospital in a timely manner.

a. Administrative days may occur prior to an acute care episode, for example, when a woman with a high risk pregnancy is admitted to a hospital while awaiting delivery.

b. Administrative days may also occur at the end of an acute care episode, for example, when a member is not discharged while awaiting placement in a nursing facility or other sub-acute or post-acute setting.

c. Administrative days may also include days in a receiving hospital when the member has been discharged from one acute care hospital for the purpose of receiving sub-acute services at the receiving hospital.

d. Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital’s administrative or operational delays.

c. Administrative days include inpatient claims covered by a RBHA or TRBHA that otherwise meet the criteria in subsection (A)(1).

2. Administrative days for claims with the principal diagnosis of behavioral health meeting inpatient medical criteria. Administrative days are days with dates of discharge on or after October 1, 2018, in which a member is admitted as an inpatient to an acute care hospital, meets the criteria for an acute inpatient stay, and the principal diagnosis on the hospital claim is a behavioral health diagnosis. Inpatient claims covered by a RBHA or TRBHA are not considered administrative days under subsection (A)(2) regardless of the principal diagnosis on the hospital claim.

B. Reimbursement of Administrative Days.

1. Administrative days under subsection (A)(1) are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate level of care such as the rate paid for stays at a nursing facility.

2. Administrative days under subsection (A)(2) are reimbursed at the daily rate found on the Inpatient Behavioral Health Capped Fee-For-Service Schedule meeting the criteria of “Service Description – Psychiatric Stay,” regardless of revenue code.

C. Prior authorization is required for administrative days.

D. A hospital shall submit a claim for administrative days separate from any claim for reimbursement for the inpatient stay otherwise reimbursable under the DRG payment methodology.

Historical Note

R9-22-712.76. DRG Reimbursement: Interim Claims

A. For inpatient stays with a length of stay greater than 29 days, a hospital may submit interim claims for each 30 day period during the inpatient stay.

B. Hospitals shall be reimbursed for interim claims at a per diem rate of $500 per day.

C. Following discharge, the hospital shall void all interim claims.

In such circumstances, the hospital shall submit a claim to the payer with whom the member is enrolled on the date of discharge, whether the Administration or a contractor, for the entire inpatient stay for which the final claim shall be reimbursed under the DRG payment methodology. Interim claims will be recouped.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).
on the date of discharge shall be reimbursed under the DRG methodology.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.78. DRG Reimbursement: Readmissions
If a member is readmitted without prior authorization to the same hospital that the member was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed only if the readmission could have been prevented by the hospital.

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.79. DRG Reimbursement: Change of Ownership
The administration shall not change any of the components of the calculation of reimbursement for inpatient services using the DRG methodology based upon a change in the hospital’s ownership except to the extent those components would change under the methodology had the hospital not changed ownership (e.g., updating the hospital’s cost-to-charge ratio as of September 1 of each year under R9-22-712.68).

Historical Note
New Section made by final rulemaking at 20 A.A.R. 1956, September 6, 2014 (Supp. 14-3).

R9-22-712.80. DRG Reimbursement: New Hospitals
A. DRG base payment for new hospitals. For any hospital that does not have a labor share or wage index published by CMS as described in subsection R9-22-712.62(B) because the hospital was not in operation, the DRG base rate described in subsection R9-22-712.62(B) shall be calculated as the statewide standardized amount after adjusting that amount for the labor-related share and the wage index published by CMS as described in subsection R9-22-712.62(B) that is appropriate to the location of the hospital published by CMS as described in subsection R9-22-712.62(B).
B. Outlier calculations for new hospitals. For any hospital that does not have an operating cost-to-charge ratio listed in the impact file described in subsection R9-22-712.68(B) because the hospital was not in operation prior to the publication of the impact file, the statewide urban or rural default operating cost-to-charge ratio appropriate to the location of the hospital and the statewide capital cost-to-charge ratio shall be used to determine the unadjusted outlier add-on payment. The statewide urban or rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio shall be based on the ratios published by CMS and updated by the Administration as described in subsection R9-22-712.68(C).
C. In addition to the requirement of this Section, DRG reimbursement for new hospitals is determined under R9-22-712.60 through R9-22-712.79.

Historical Note

R9-22-712.81. DRG Reimbursement: Updates
In addition to the other updates provided for in Sections R9-22-712.60 through R9-22-712.80, the Administration may update the version of the APR-DRG classification system established by 3M Health Information Systems, adjust the statewide standardized amount in Section R9-22-712.62, the base payments in sections R9-22-712.63 and R9-22-712.64, the provider policy adjustor in section R9-22-712.65, service policy adjustors Section R9-22-712.66, and the fixed loss amounts and marginal cost percentages used to calculate the outlier threshold in Section R9-22-712.68 to the extent necessary to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area. The Administration shall publish any proposed classification system on the agency’s website at least 30 days prior to the effective date, to ensure a sufficient period for public comment, as required by 42 C.F.R. § 447.205. In addition, the public notice shall be available for inspection during normal business hours at 701 E. Jefferson, Phoenix, Arizona. The requirements of 42 CFR § 447.205 as of November 2, 2015 are incorporated by reference and do not include any later amendments.

Historical Note

R9-22-712.90. Reimbursement of Hospital-based Freestanding Emergency Departments
A. “Hospital-based freestanding emergency department” (hospital-based FSED) means an outpatient treatment center, as defined in R9-10-101, that: (1) provides emergency room services under R9-10-1019, (2) is subject to the requirements of 42 CFR 489.24, and (3) shares an ownership interest with a hospital, regardless of whether the outpatient treatment center operates under a hospital’s single group license as described in A.R.S. § 36-422.
B. A hospital-based FSED shall register with the Administration separately from the hospital with which an ownership interest is shared and shall obtain a separate provider identification number. The Administration shall not charge a separate provider enrollment fee for registration of a hospital-based FSED. The Administration shall accept a hospital’s compliance with the provider screening and enrollment requirements of 42 CFR Part 455 as compliance by the hospital-based FSED.
C. For dates of service on and after March 1, 2017, and except as provided in subsection (D), services provided by a hospital-based FSED for evaluation and management CPT codes 99281 through 99285 shall be reimbursed at the following percentages of the amounts otherwise reimbursable under sections R9-22-712.20 through R9-22-712.30. All other covered codes shall be reimbursed in accordance with sections R9-22-712.20 through R9-22-712.30 without a percentage reduction.
1. 60% for a level 1 emergency department visit as indicated by CPT 99281.
2. 80% for a level 2 emergency department visit as indicated by CPT 99282.
3. 90% for a level 3 emergency department visit as indicated by CPT 99283.
4. 100% for a level 4 or 5 emergency department visit as indicated by CPT codes 99284 and 99285.
D. A hospital-based FSED located in a city or town in a county with less than 500,000 residents, where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed under sections R9-22-712.20 through R9-22-712.35 using the adjustment in R9-22-712.35 associated with the nearest hospital with which the
freestanding emergency department shares an ownership interest.

E. Services provided by an outpatient treatment center that provides emergency room services under R9-10-1019, but does not otherwise meet the criteria in subsection A, shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule under R9-22-710.

F. The Administration shall not reimburse a hospital for services provided at a hospital-based FSED if the member is admitted directly from a hospital-based FSED to a hospital with an ownership interest in the hospital-based FSED. As provided in R9-22-712.60(B), payments made for the inpatient stay using the DRG methodology shall be the sole reimbursement.

Historical Note
New Section made by final rulemaking at 23 A.A.R. 22, February 11, 2017 (Supp. 16-4).

R9-22-713. Overpayment and Recovery of Indebtedness
A. If a contractor or a subcontracting provider receives an overpayment from the Administration or otherwise becomes indebted to the Administration, the contractor or subcontracting provider shall immediately remit the amount of the indebtedness or overpayment to the Administration for deposit in the AHCCCS fund.

B. If the funds described in subsection (A) are not remitted, the Administration may recover the funds paid by the Administration to a contractor or subcontracting provider through:
   1. A repayment agreement executed with the Administration;
   2. Withholding or offsetting against current or future payments to be paid to the contractor or subcontracting provider; or
   3. Enforcement of, or collection against, the performance bond, financial reserve, or other financial security under A.R.S. § 36-2903.

Historical Note

R9-22-714. Payments to Providers
A. Provider agreement. The Administration or a contractor shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904.

B. Provider reimbursement. The Administration or a contractor shall reimburse a provider for a service furnished to a member only if:
   1. The provider personally furnishes the service to a specific member. For purposes of this Section, services personally furnished by a provider include:
      a. Services provided by medical residents or dental students in a teaching environment; or
      b. Services provided by a licensed or certified assistant under the general supervision of a licensed practitioner in accordance with 4 A.A.C. 24, 9 A.A.C. 16, 4 A.A.C. 43, or 4 A.A.C. 45;
   2. The provider verifies that individuals who have provided services described in subsection (B)(1) have not been placed on the List of Excluded Individuals/Entities (LEIE) maintained by the United States Department of Health and Human Services Office of the Inspector General (OIG), located at OIG’s web site;
   3. The service contributes directly to the diagnosis or treatment of the member; and
   4. The service ordinarily requires performance by the type of provider seeking reimbursement.

C. The Administration or a contractor may make a payment for covered services only:
   1. To the provider;
   2. To anyone specified in a reassignment from the provider to a government agency or reassignment by a court order;
   3. To a business agent, if the agent’s compensation for the service is:
      a. Related to the cost of processing the billing;
      b. Not related on a percentage or other basis to the amount that is billed or collected; and
      c. Not dependent upon collection of the payment;
   4. To the employer of the provider, if the provider is required as a condition of employment to turn over the provider’s fees to the employer;
   5. To the inpatient facility in which the service is provided, if the provider has a contract under which the inpatient facility submits the claim; or
   6. To a foundation, plan, or similar organization operating an organized health care delivery system, if the provider has a contract under which the foundation, plan or similar organization submits the claim.

D. The Administration or a contractor shall not make a payment to or through a factor, either directly or by power of attorney, for a covered service furnished to a member by a provider.

E. Reimbursement for a pathology service. Unless otherwise specified in a contract, the Administration or a contractor shall reimburse a pathologist for a pathology service furnished to a member only if the other requirements in this Section are met and the service is:
   1. A surgical pathology service;
   2. A specific cytopathology, hematology, or blood banking pathology service that requires performance by a physician and is listed in the capped fee-for-service schedule;
   3. A clinical consultation service that:
      a. Is requested by the member’s attending physician or primary care physician,
      b. Is related to a test result that is outside the clinically significant normal or expected range in view of the condition of the member,
      c. Results in a written narrative report included in the member’s medical record,
      d. Requires the exercise of medical judgment by the consultant pathologist, and
      e. Is listed in the capped fee-for-service schedule; or
   4. A clinical laboratory interpretative service that:
      a. Is requested by the member’s attending physician or primary care physician,
      b. Results in a written narrative report included in the member’s medical record,
      c. Requires the exercise of medical judgment by the consultant pathologist, and
      d. Is listed in the capped fee-for-service schedule.
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Historical Note

Editor’s Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-715. Hospital Rate Negotiations
A. A contractor that negotiates with hospitals for inpatient or outpatient services shall reimburse hospitals for services rendered on or after March 1, 1993, as described in A.R.S. § 36-2903.01 and this Article, or at the negotiated rate that, in the aggregate, does not exceed reimbursement levels that would have been paid under A.R.S. § 36-2903.01, and this Article. This subsection does not apply to urban hospitals described under R9-22-718. Contractors may engage in rate negotiations with a hospital at any time during the contract period.
B. The Administration may negotiate or contract with a hospital on behalf of a contractor for discounted hospital rates and may require that the negotiated discounted rates be included in a subcontract between the contractor and hospital.

Historical Note

Editor’s Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council; the agency did not submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rules; and the Attorney General did not certify this rule. This Section was subsequently amended through the regular rulemaking process.

R9-22-716. Repealed

R9-22-717. Repealed

Historical Note
Adopted effective July 30, 1993 (Supp. 93-3). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 11 A.A.R. 3222, effective October 1, 2005 (Supp. 05-3).

Editor’s Note: The following Section was originally adopted under an exemption from the provisions of the Administrative Procedure Act which means that this rule was not reviewed by the Governor’s Regulatory Review Council. The agency was required to submit notice of proposed rulemaking to the Secretary of State for publication in the Arizona Administrative Register; and was required to hold a public hearing. It has since been amended under the regular rulemaking process.

R9-22-718. Urban Hospital Inpatient Reimbursement Program
A. Definitions. The following definitions apply to this Section:
1. “Contractor” has the same meaning as set forth in A.R.S. § 36-2901, and includes all contractors regardless of whether the GSA’s served by the contractor includes urban or rural counties.
2. “Noncontracted Hospital” means an urban hospital, including psychiatric hospitals, which does not have a contract under this Section with a contractor.
3. “Urban Hospital” means a hospital that is not a rural hospital, as defined in R9-22-712.07, and that is physically located in Maricopa or Pima County.

B. General Provisions.
1. This Section applies to an urban hospital who receives payment for inpatient hospital services under A.R.S. §§ 36-2903.01 and 36-2904.
2. AHCCCS shall operate an inpatient hospital reimbursement program under A.R.S. § 36-2903.01 and this Section.
3. Residency of the member receiving inpatient AHCCCS covered services is not a factor in determining which hospitals are required to contract with which contractors.
4. A contractor shall enter into a contract for reimbursement for inpatient AHCCCS covered services with one or more urban hospitals located in the same county as the contractor.
5. A noncontracted urban hospital shall be reimbursed for inpatient services by a contractor at 95% of the amount calculated as defined in A.R.S. § 36-2903.01 and this Article, unless otherwise negotiated by both parties.

C. Contract Begin Date. A contract under this Article shall cover inpatient acute care hospital services for members with hospital admissions on and after October 1, 2003.

D. Outpatient urban hospital services. Outpatient urban hospital services, including observation days and emergency room treatments that do not result in an admission, shall be reimbursed either through an urban hospital contract negotiated between a contractor and an urban hospital, or the reimbursement rates set forth in A.R.S. § 36-2903.01.
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rulemaking at 24 A.A.R. 1515, effective June 30, 2018 (Supp. 18-2).

R9-22-719. Contractor Performance Measure Outcomes
The Administration may retain a specified percentage of capitation reimbursement to distribute to contractors based on their performance measure outcomes under A.R.S. § 36-2904. The Administration shall notify contractors 60 days prior to a new contract year if this methodology is implemented. The Administration shall specify the details of the reimbursement methodology in contract.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 424, effective January 10, 2002 (Supp. 02-1).

R9-22-720. Reinsurance
A. Reinsurance is a stop-loss program provided by the Administration to a contractor for partial reimbursement of the cost of covered services for a member with an acute medical condition when the cost of covered services exceeds a pre-determined deductible level amount within a contract year. The Administration self-insures the reinsurance program through a reduction to capitation rates. The reinsurance program also includes a catastrophic reinsurance program for members diagnosed with specific medical conditions.

B. The Administration shall specify in contract guidelines for claims submission, processing, payment, and the types of care and services that are provided to a member whose care is covered by reinsurance.

C. When the Administration determines that a contractor does not follow the specified guidelines for care or services and the care or services could have been provided at a lower cost according to the guidelines, the Administration shall reimburse the contractor as if the care or services had been provided as specified in the guidelines.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 3317, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 13 A.A.R. 856, effective May 5, 2007 (Supp. 07-1).

R9-22-721. Behavioral Health Inpatient Facilities
“Behavioral health inpatient facility” means a health care institution, other than Arizona State Hospital, that meets the following requirements:

1. Provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
   a. Have a limited or reduced ability to meet the individual’s basic physical needs;
   b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
   c. Be a danger to self;
   d. Be a danger to others;
   e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
   f. Be gravely disabled; and

2. Is one of the following facility types:
   a. Psychiatric hospitals;
   b. Mental health residential treatment centers;
   c. Secure residential treatment centers with 17 or more beds;
   d. Non-secure residential treatment centers with 1-16 beds;
   e. Non-secure residential treatment centers with 17 or more beds;
   f. Sub-acute facilities with 1-16 beds;

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g. Sub-acute facilities with 17 or more beds.

Historical Note
New Section made by final rulemaking at 25 A.A.R. 3120, effective October 1, 2019 (Supp. 19-4).

R9-22-722. Reserved
R9-22-723. Reserved
R9-22-724. Reserved
R9-22-725. Reserved
R9-22-726. Reserved
R9-22-727. Reserved
R9-22-728. Reserved
R9-22-729. Reserved

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 1041 (Supp. 15-3).

Editor’s Note: Amendments to Section R9-22-730 were filed as a final exempt rulemaking. AHCCCS provided an opportunity for public comment on the amended rules under Laws 2013, 1st Special Session, Ch. 10. A proposed exempt rulemaking was published in the Arizona Administrative Register at 21 A.A.R. 491 (Supp. 15-2).

R9-22-730. Hospital Assessment Fund - Hospital Assessment

A. For purposes of this Section, the following terms are defined as provided below unless the context specifically requires another meaning:


3. “Quarter” means the three month period beginning January 1, April 1, July 1, and October 1 of each year.

4. A “new hospital” means a licensed hospital that did not hold a license from the Arizona Department of Health Services prior to January 2, 2021.

5. “Outpatient Net Patient Revenues” means an amount, calculated using data in the hospital’s 2019 Uniform Accounting Report, that is equal to the hospital’s 2019 total net patient revenue multiplied by the ratio of the hospital’s 2019 gross outpatient revenue to the hospital’s 2019 total gross patient revenue.

B. Beginning January 1, 2014, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2021, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s 2019 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as “Other Long Term Care Discharges,” multiplied by the following rates appropriate to the hospital’s peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital’s peer group:

1. $748.50 per discharge and 1.3700% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.

2. $748.50 per discharge and 0.5708% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.

3. $187.25 per discharge and 0.5708% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.

4. $187.25 per discharge and 0.5708% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2019 Medicare Cost Report.

5. $598.75 per discharge and 1.4842% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with below 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2019 Uniform Accounting Report.

6. $673.50 per discharge and 1.7125% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2019 Uniform Accounting Report.

7. $149.75 per discharge and 0.4567% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children’s.

8. $748.50 per discharge and 2.2384% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.

C. Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2021.

D. Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital’s 2019 Medicare Cost Report, are assessed a rate of $187.25 for each discharge from the psychiatric sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).

E. Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital’s 2019 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2019 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).

F. Notwithstanding subsection (B), for any hospital that reported more than 23,000 discharges on the hospital’s 2019 Medicare Cost Report, discharges in excess of 23,000 are assessed a rate of $75.00 for each discharge in excess of 23,000. The initial 23,000 discharges are assessed at the rate required by subsection (B).

G. Assessment notice. On or before the 15th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the Hospital Assessment Fund assessment invoice is
available to be viewed on a secure website. The invoice shall include the hospital’s peer group assignment and the assessment due for the quarter.

H. Assessment due date. The Hospital Assessment Fund assessment must be received by the Administration no later than:
   1. The 15th day of the second month of the quarter or
   2. In the event CMS approves the assessment after the 15th day of the first month of the quarter, 30 days after notification by the Administration that the assessment invoice is available.

I. Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital’s 2019 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2021:
   1. Hospitals owned and operated by the state, the United States, or an Indian tribe.
   2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning “SH”.
   5. Hospitals designated as type: med-hospital, subtype: special hospitals.
   6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2019 Medicare Cost Report are reimbursed by Medicare.
   7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as a percentage of total Medicare days, per the 2019 Medicare Cost Report.

J. New hospitals. For hospitals that did not file a 2019 Medicare Cost Report because of the date the hospital began operations:
   1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.
   2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.
   3. A hospital is not considered a new hospital based on a change in ownership.
   4. The assessment will be based on the discharges reported in the hospital’s first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:
      a. If there is not a complete 12 months-worth of data available, the assessment will be based on the actualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. “Annualized” means divided by a ratio equal to the number of months of data divided by 12 months.
      b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;
   5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital instead of the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.
   6. For hospitals providing self-reported data, described in subpart 4 and 5:
      a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.
      b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.

K. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.

L. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.

M. Required information for the inpatient assessment. For any hospital that has not filed a 2019 Medicare Cost report, or if the 2019 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2019 Uniform Accounting Report filed by the hospital in place of the 2019 Medicare Cost report to calculate the assessment. If the 2019 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the assessment.

N. Required information for the outpatient assessment. For any hospital that has not filed a 2019 Uniform Accounting Report, or if the 2019 Uniform Accounting Report does not reconcile to 2019 Audited Financial Statements, the Administration shall use the data reported on 2019 Audited Financial Statements to calculate the outpatient assessment. If the 2019 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment, the Administration all use data reported on the 2019 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2019 Medicare Cost report to calculate the outpatient assessment.

O. The Administration will review and update as necessary rates and peer groups periodically to ensure the assessment is sufficient to fund the state match obligation to cover the cost of the populations as specified in A.R.S. § 36-2901.08.

P. Enforcement. If a hospital does not comply with this Section, the director may suspend or revoke the hospital’s provider agreement. If the hospital does not comply within 180 days after the hospital’s provider agreement is suspended or
revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital’s license.

**Historical Note**


**R9-22-731. Health Care Investment Fund - Hospital Assessment**

**A.** For purposes of this Section, terms are the same as defined in R9-22-730 as provided below unless the context specifically requires another meaning.

**B.** Beginning October 1, 2020, for each Arizona licensed hospital not excluded under subsection (I) shall be subject to an assessment payable on a quarterly basis. The assessment shall be levied against the legal owner of each hospital as of the first day of the quarter, and except as otherwise required by subsections (D), (E) and (F). For the period beginning October 1, 2020, the assessment for each hospital shall be amount equal to the sum of: (1) the number of discharges reported on the hospital’s 2018 Medicare Cost Report, excluding discharges reported on the Medicare Cost Report as “Other Long Term Care Discharges,” multiplied by the following rates appropriate to the hospital’s peer group; and (2) the amount of outpatient net patient revenues multiplied by the following rate appropriate to the hospital’s peer group:

1. $151.50 per discharge and 2.5886% of outpatient net patient revenues for hospitals located in a county with a population less than 500,000 that are designated as type: hospital, subtype: short-term.

2. $151.50 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: critical access hospital.

3. $38.00 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: long term.

4. $38.00 per discharge and 1.0786% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: psychiatric, that reported 2,500 or more discharges on the 2018 Medicare Cost Report.

5. $121.25 per discharge and 2.8043% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2018 Uniform Accounting Report.

6. $136.50 per discharge and 3.2357% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term with at least 10% but less than 20% of total licensed beds licensed as pediatric, pediatric intensive care and neonatal intensive care as reported in the hospital’s 2018 Uniform Accounting Report.

7. $30.50 per discharge and 0.8629% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: children’s.

8. $151.50 per discharge and 4.3143% of outpatient net patient revenues for hospitals designated as type: hospital, subtype: short-term not included in another peer group.

**C.** Peer groups for the four quarters beginning October 1 of each year are established based on hospital license type and subtype designated in the Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website January 2, 2020.

**D.** Notwithstanding subsection (B), psychiatric discharges from a hospital that reported having a psychiatric sub-provider in the hospital’s 2018 Medicare Cost Report, are assessed a rate of $38.00 for each discharge from the psychiatric sub-provider as reported in the 2018 Medicare Cost Report. All discharges other than those reported as discharges from the psychiatric sub-provider are assessed at the rate required by subsection (B).

**E.** Notwithstanding subsection (B), rehabilitative discharges from a hospital that reported having a rehabilitative sub-provider in the hospital’s 2018 Medicare Cost Report, are assessed a rate of $0 for each discharge from the rehabilitative sub-provider as reported in the 2018 Medicare Cost Report. All discharges other than those reported as discharges from the rehabilitative sub-provider are assessed at the rate required by subsection (B).

**F.** Notwithstanding subsection (B), for any hospital that reported more than 24,000 discharges on the hospital’s 2018 Medicare Cost Report, discharges in excess of 24,000 are assessed a rate of $15.25 for each discharge in excess of 24,000. The initial 24,000 discharges are assessed at the rate required by subsection (B).

**G.** Assessment notice. On or before the 20th day of the first month of the quarter or upon CMS approval, whichever is later, the Administration shall send to each hospital a notification that the assessment invoice is available to be viewed on a secure website. The invoice shall include the hospital’s peer group assignment and the assessment due for the quarter.

**H.** Assessment due date. The assessment must be received by the Administration no later than the 20th day of the second month of the quarter.

**I.** Excluded hospitals. The following hospitals are excluded from the assessment based on the hospital’s 2018 Medicare Cost Report and Provider & Facility Database for Arizona Medical Facilities posted by the Arizona Department of Health Services Division of Licensing Services on its website for January 2, 2020:

1. Hospitals owned and operated by the state, the United States, or an Indian tribe.

2. Hospitals designated as type: hospital, subtype: short-term that have a license number beginning “SH”.


5. Hospitals designated as type: med-hospital, subtype: special hospitals.

6. Hospitals designated as type: hospital, subtype: short-term located in a city with a population greater than one
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million, which on average have at least 15 percent of inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2018 Medicare Cost Report are reimbursed by Medicare.

7. Hospitals designated as type: hospital, subtype: short-term that have at least 25 percent Medicare swing beds as percentage of total Medicare days, per the 2018 Medicare Cost Report.

J. New hospitals. For hospitals that did not file a 2018 Medicare Cost Report because of the date the hospital began operations:

1. If the hospital was open on the January 2 preceding the October assessment start date, the hospital assessment will begin on October 1 following the date the hospital began operating.

2. If the hospital began operating between January 3 and June 30, the assessment will begin on October 1 of the following calendar year.

3. A hospital is not considered a new hospital based on a change in ownership.

4. The assessment will be based on the discharges reported in the hospital’s first Medicare Cost Report and Uniform Accounting Report, which includes 12 months-worth of data, except when any of the following apply:

   a. If there is not a complete 12 months-worth of data available, the assessment will be based on the annualized number of discharges from the date hospital operations began through December 31 preceding the October assessment start date. The hospital shall self-report the discharge data and all other data requested by the Administration necessary to determine the appropriate assessment to the Administration no later than January preceding the assessment start date for the new hospitals. “Annualized” means divided by a ratio equal to the number of months of data divided by 12 months.

   b. If more than 12 months of data is available, the assessment will be based on the most recent 12 months of self-reported data, as of December 31;

5. For purposes of calculating subpart 4, if a new hospital shares a Medicare Identification Number with an existing hospital, the assessment amount will be based on self-reported data from the new hospital and the Medicare Cost Report. The data shall include the number of discharges and all other data requested by the Administration necessary to determine the appropriate assessment.

6. For hospitals providing self-reported data, described in subpart 4 and 5:

   a. Psychiatric discharges will be annualized to determine if subsections (B)(4) or (I)(3) apply to the assessment amount.

   b. Discharges will be annualized to determine if subsection (F) applies to the assessment amount.

L. Changes of ownership. The parties to a change of ownership shall promptly provide written notice to the Administration of a change of ownership and any agreement regarding the payment of the assessment. The assessed amount will continue at the same amount applied to the prior owner. Assessments are the responsibility of the owner of record as of the first day of the quarter; however, this rule is not intended to prohibit the parties to a change of ownership from entering into an agreement for a new owner to assume the assessment responsibility of the owner of record as of the first day of the prior quarter.

M. Hospital closures. Hospitals that close shall pay a proportion of the quarterly assessment equal to that portion of the quarter during which the hospital operated.

N. Required information for the inpatient assessment. For any hospital that has not filed a 2018 Medicare Cost report, or if the 2018 Medicare Cost report does not include the reliable information sufficient for the Administration to calculate the inpatient assessment, the Administration shall use data reported on the 2018 Uniform Accounting Report filed by the hospital in place of the 2018 Medicare Cost report to calculate the assessment. If the 2018 Uniform Accounting Report filed by the hospital does not include reliable information sufficient for the Administration to calculate the inpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2018 Medicare Cost report to calculate the assessment.

O. Required information for the outpatient assessment. For any hospital that has not filed a 2018 Uniform Accounting Report, or if the 2018 Uniform Accounting Report does not reconcile to 2018 Audited Financial Statements, the Administration shall use the data reported on 2018 Audited Financial Statements to calculate the outpatient assessment. If the 2018 Audited Financial Statements do not include the reliable information sufficient for the Administration to calculate the outpatient assessment assessment, the Administration all use data reported on the 2018 Medicare Cost report. If the Medicare Cost report does not include reliable information sufficient for the Administration to calculate the outpatient assessment amounts, the hospital shall provide the Administration with data specified by the Administration necessary in place of the 2018 Medicare Cost report to calculate the outpatient assessment.

P. Enforcement. If a hospital does not comply with this section, the director may suspend or revoke the hospital’s provider agreement. If the hospital does not comply within 180 days after the hospital’s provider agreement is suspended or revoked, the director shall notify the director of the Department of Health Services who shall suspend or revoke the hospital’s license.

Historical Note
New Section made by final exempt rulemaking at 26 A.A.R. 2984, effective October 1, 2020 (Supp. 20-4).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-22-801 through R9-22-804 and Exhibit A, repealed by final rulemaking at 10 A.A.R. 808, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-22-801. Repealed

Historical Note
Adopted as an emergency effective May 20, 1982, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 82-3). Former Section R9-22-801 adopted as an emergency adoption now adopted and amended as a permanent rule effective August 30, 1982 (Supp. 82-4). Former Section R9-22-801 repealed, new Section R9-22-801 adopted effective October 29, 1985 (Supp. 85-5). Amended subsection (C), (F), (H), (I), and (K) effective October 1, 1986 (Supp. 86-5). Change of heading only effective January 1, 1987, filed December 31, 1986 (Supp. 86-6). Amended subsection (H) effective May 30, 1989 (Supp. 89-2). Amended effective September 29, 1992 (Supp. 92-3). Section heading amended under an exemption from the provisions of the Administrative Procedure Act, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective October 26, 1993 (Supp. 93-4). Amended effective December 13, 1993 (Supp. 93-4). Former Section R9-22-801 repealed, new Section R9-22-
36-2903.01. Additional powers and duties; report; definition

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

   (a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

   (b) Establish performance measures and incentives for the department.

   (c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

   (d) Establish eligibility quality control reviews by the administration.

   (e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

   (f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

   (g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

   (h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months
after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and
medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio.
ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall
include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.
(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H.
The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

   (a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

   (b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

   (c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.
L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.
2. A copayment of five dollars for each physician office visit.

3. A copayment of ten dollars for each urgent care visit.

4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.
36-2906. Qualified plan health services contracts; proposals; administration

A. The administration shall:

1. Supervise the administrator.

2. Review the proposals.

3. Award contracts.

B. The director shall prepare and issue a request for proposal, including a proposed contract format, in each of the counties of this state, at least once every five years, to qualified group disability insurers, hospital and medical service corporations, health care services organizations and any other qualified public or private persons, including county-owned and operated health care facilities. The contracts shall specify the administrative requirements, the delivery of medically necessary services and the subcontracting requirements.

C. The director shall adopt rules regarding the request for proposal process that provide:

1. For definition of proposals in the following categories subject to the following conditions:

(a) Inpatient hospital services.

(b) Outpatient services, including emergency dental care, and early and periodic health screening and diagnostic services for children.

(c) Pharmacy services.

(d) Laboratory, x-ray and related diagnostic medical services and appliances.

2. Allowance for the adjustment of such categories by expansion, deletion, segregation or combination in order to secure the most financially advantageous proposals for the system.

3. An allowance for limitations on the number of high risk persons that must be included in any proposal.

4. For analysis of the proposals for each geographic service area as defined by the director to ensure the provision of health and medical services that are required to be provided throughout the geographic service area pursuant to section 36-2907.

5. For the submittal of proposals by a group disability insurer, a hospital and medical service corporation, a health care services organization or any other qualified public or private person intending to submit a proposal pursuant to this section. Each qualified proposal shall be entered with separate categories for the distinct groups of persons to be covered by the proposed contracts, as set forth in the request for proposal.

6. For the procurement of reinsurance for expenses incurred by any contractor or member or the system in providing services in excess of amounts specified by the director in any contract year. The director shall adopt rules to provide that the administrator may specify guidelines on a case by case basis for the types of care and services that may be provided to a person whose care is covered by reinsurance. The rules shall provide that if a contractor does not follow specified guidelines for care or services and if the care or services could be provided pursuant to the guidelines at a lower cost the contractor is entitled to reimbursement as if the care or services specified in the guidelines had been provided.

7. For the awarding of contracts to contractors with qualified proposals determined to be the most advantageous to the state for each of the counties in this state. A contract may be awarded that provides services only to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e). The director may provide by rule a second round competitive proposal procedure for the director to request voluntary price
reduction of proposals from only those that have been tentatively selected for award, before the final award or rejection of proposals.

8. For the requirement that any proposal in a geographic service area provide for the full range of system covered services.

9. For the option of the administration to waive the requirement in any request for proposal or in any contract awarded pursuant to a request for proposal for a subcontract with a hospital for good cause in a county or area including but not limited to situations when such hospital is the only hospital in the health service area. In any situation where the subcontract requirement is waived, no hospital may refuse to treat members of the system admitted by primary care physicians or primary care practitioners with hospital privileges in that hospital. In the absence of a subcontract, the reimbursement level shall be at the levels specified in section 36-2904, subsection H or I.

D. Reinsurance may be obtained against expenses in excess of a specified amount on behalf of any individual for system covered emergency or inpatient services either through the purchase of a reinsurance policy or through a system self-insurance program as determined by the director. Reinsurance, subject to the approval of the director, may be obtained against expenses in excess of a specified amount on behalf of any individual for outpatient services either through the purchase of a reinsurance policy or through a system self-insurance program as determined by the director.

E. Notwithstanding the other provisions of this section, the administration may procure, provide or coordinate system covered services by interagency agreement with authorized agencies of this state or with a federal agency for distinct groups of eligible persons, including persons eligible for children's rehabilitative services through the department of economic security and persons eligible for comprehensive medical and dental program services through the department of child safety.

F. Contracts shall be awarded as otherwise provided by law, except that in no event may a contract be awarded to any respondent that will cause the system to lose any federal monies to which it is otherwise entitled.

G. After contracts are awarded pursuant to this section, the director may negotiate with any successful proposal respondent for the expansion or contraction of services or service areas if there are unnecessary gaps or duplications in services or service areas.
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| **Contract language:** Appointment Availability, Transportation Timeliness, Monitoring, and Reporting | The Contractor shall actively monitor and track provider compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as specified in AHCCCS Contractor Operations Manual *(ACOM)* Policy 417 [42 CFR 438.206(c)(1)].

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall develop and implement performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met. |
**Contract language:**

Subcontracts

*(NEMT Brokers are Administrative Services Subcontractors)*

The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

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| ACOM Policy 417, Transportation Timeliness Deliverable format | Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs
Total Pickups, Timely Pickups, % of Timely Pickups |
|---|---|

**Deliverable Data**

For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pickup trips were timely
| Strategy to Resolve NEMT Concerns: AHCCCS NEMT Workgroup | AHCCCS created an Internal NEMT workgroup which meets every six weeks.  
This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison).  
The Workgroup discusses concerns around NEMT services in general, as well as policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members. |
| Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers | MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.  
One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides. |
| **Contract language:** Member Complaint/Grievance requirements | At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.

The Contractor shall address identified issues as expeditiously as the member’s condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)]. |
| **Contract Language:** Quality Management and Quality of Care requirements | The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.

The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].

The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter. |
| AMPM Policy 960, Quality of Care Concerns | The Contractor shall develop and implement policies and procedures to review, report, evaluate, and resolve Quality of Care (QOC) concerns and service concerns raised by members/Health Care Decision Makers (HCDM)s, contracted providers, and stakeholders. Concerns may be received from anywhere within the organization or externally from anywhere in the community including provider incident, accident, and death reports entered directly into the AHCCCS Quality Management (QM) Portal as specified in AMPM Policy 961. All concerns shall be addressed regardless of source (external or internal). QOC concerns involving both physical and behavioral health providers or services shall be addressed in the same manner.  

...  

The Contractor shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as directed by AHCCCS, inclusive of QOC concerns, quality of service, and immediate care needs.  

a. The data from the tracking and trending system shall be analyzed and evaluated to identify and address any trends related to members, providers, the QOC process or services in the Contractor’s service delivery system or provider network. The Contractor is responsible for incorporating trending of QOC concerns in determining systemic interventions for quality improvement,  

b. The Contractor shall ensure that tracking and trending information is submitted, reviewed, and considered for action by the Contractor’s local QM Committee and local Medical Director, as Chairman of the QM Committee,  

c. If significant negative trends are noted, the Contractor should consider developing performance improvement activities focused on the topic area to improve the concern resolution process itself, and to make improvements that address other system issues raised during the resolution process,  

d. The Contractor shall ensure that tracking and trending information related to provider education, training, and staff credentialing is shared with the workforce development operation as specified in ACOM Policy 407, ... |

The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Quality Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor shall comply with requirements, as specified in Contract and AMPM Policy 960.
| AHCCCS Review of Quality of Care (QOC) cases | The majority of the QOC investigative work is completed by the MCOs with oversight, monitoring, and auditing of cases completed by AHCCCS. QOCs can be submitted to either an MCO directly or to AHCCCS. If submitted directly to AHCCCS, staff review the concern, research the MCO that the member is enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: [https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf)

MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in [AMPM Policy 960](#); MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions. |
| AHCCCS Access to Care Committee | AHCCCS has an Access to Care Committee which meets quarterly.

This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services.

This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona. |
### Additional Relevant Requirements

| Contract Language: Periodic Reporting Requirements | Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions. Standards applied for determining adequacy of required reports are as follows:  
1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.  
2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.  
3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions |

| Contract Language: Administrative Actions | Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, [ACOM Policy 408](#), [ACOM Policy 440](#), Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract. |
Background:
In the August 2, 2022 meeting of the Governor’s Regulatory Review Council (GRRC), in the discussion of AHCCCS’s 5 Year Review Report for rules in Title 9, Chapter 28, Articles 6 & 7, the Council requested further information be provided regarding AHCCCS’s oversight, monitoring, and sanctions with regards to provision of Non-Emergency Medical Transportation (NEMT) service. This document is to provide the Council with an update on the agency’s next steps in addressing the Council’s concerns, following internal workgroups and discussions with AHCCCS’s Managed Care Organizations (MCOs). Additionally, the attached document contains further information regarding AHCCCS’s existing contract and policy requirements that govern provision of NEMT services relevant to this request.

Due to the complicated nature of providing NEMT services that meet their members’ needs appropriately, State Medicaid Agencies often approach management and delivery of the NEMT benefit differently and with varying levels of success. States and other entities that administer NEMT benefits, including Medicaid MCOs and third-party transportation brokers, are engaged in a number of efforts to improve NEMT program administration, program integrity, and beneficiary experience. Arizona was recently highlighted in a Medicaid and CHIP Payment and Access Commission (MACPAC) June 2021 Report to Congress that covered some of these recurring issues with the provision of NEMT services, which highlighted AHCCCS’s efforts to be adaptive to member needs. AHCCCS maintains a standing internal NEMT workgroup to address concerns and be responsive to members’, MCOs’, and providers’ potential NEMT issues.

Updates:
The August 2, 2022 Council concerns and requests include the following:

- Raised specific concerns about how member grievances regarding NEMT are handled and how AHCCCS communicates the available options for grievances to members.
  - Information regarding member grievances is included in the attachment.
- Requested that AHCCCS share MCO contract requirements regarding NEMT, as well as information regarding how NEMT concerns are resolved.
  - AHCCCS MCO contract requirements for the provision of NEMT, and information regarding how NEMT concerns are resolved, are attached.
- Requested AHCCCS provide MCO contract requirements regarding quality assurance and quality of care concerns.
  - MCO quality assurance and quality of care contract requirements are detailed in the attachment.
- Requested information regarding how AHCCCS communicates NEMT services, and the different level or mobility issues covered by those services, to members.
  - AHCCCS MCO contract requirements relative to meeting the transportation needs of the member, and how AHCCCS communicates to members how they access NEMT, are attached.
AHCCCS is working with its NEMT Workgroup, and has reached out to its MCOs, to investigate and address the concerns raised by the Council. Thus far, the following actions have been taken:

- AHCCCS requested and received information from its MCOs regarding how the timeliness statistics for NEMT drop offs and pick-ups are calculated:
  - Numerator = Number of timely trips completed, where timely is defined as:
    - Drop-offs: No more than one hour before the medical appointment
    - Pick-ups: Member waiting no more than one hour after the end of treatment
    - These one hour limits are in accordance with AHCCCS Policy
  - Denominator = Total number of completed trips

- AHCCCS additionally requested information from its MCOs regarding the collection of canceled or rescheduled trips (not currently required by AHCCCS), to have the most complete picture possible of the member experience. The collection of this information is still in process.

- AHCCCS has communicated with MCOs to determine if they have a special designation/process for NEMT access to care for members with high health care needs (not currently required by AHCCCS). All MCOs confirmed that they do offer special assistance for high need members. AHCCCS learned that communication regarding how this service is handled is inconsistent among MCOs. For example, some MCOs put this information in their member handbooks, and some train case managers how to make this determination.

AHCCCS is examining the following strategies to address concerns surrounding NEMT:

- AHCCCS will add NEMT timeliness statistics to the Health Plan Report Card on the AHCCCS website so it is available to the public.

- AHCCCS is developing contract and policy language regarding MCOs tracking of provider cancellations/rescheduled trips and reporting the data to AHCCCS.
  - This data will be added to the Health Plan Report Card upon future receipt of the new deliverable.

- Based on the MCO feedback regarding the special assistance for members with high health care needs, AHCCCS intends to work with MCOs to standardize the high-need member designation across plans; and to develop, and consistently deliver, member communication regarding qualifications for, and how to request, such a designation from their MCO.

- AHCCCS has announced a grants program using funds generated by the American Rescue Plan (ARP) Act to expand, enhance and strengthen home and community based services (HCBS). This grant program should be available in mid-2023. It is AHCCCS’ hope that interested HCBS providers (including but not limited to assisted living facilities) would consider applying for grants to acquire vehicles to transport wheelchair utilizing and scooter-dependent resident members. Such activity would expand access to transportation services to the benefit of all members. When a qualified HCBS provider successfully applies to AHCCCS to add a transportation service to their provider profile, that provider would be paid for the provision of qualifying NEMT services. (Read more about the grants program in the AHCCCS ARPA HCBS Spending Plan on page 11.)
Finally, AHCCCS believes it is important to point out the significant number of NEMT services offered annually in order to offer some context around the NEMT statistics. In the attachment, AHCCCS reports six months of NEMT timeliness data for completed trips in contract year ending (CYE) 2022, from October 1, 2021 through March 31, 2022:

- 92.50% of 638,948 total drop off trips were timely
- 98.05% of 570,725 total pick up trips were timely

It is important to note that, on an annualized basis, over 1.2 million drop offs will occur over the 12 months of CYE 2022, and over 1 million pickups. In total that is more than 2 million completed NEMT services in CYE 2022. While a 92% timeliness rate for drop off trips, and a 98% timeliness rate for pick ups, do convey high timeliness adherence, we will still expect to see approximately 120,000 member trips, and possibly an equal number of members impacted. These high numbers (despite the low percentages) can and do result in numerous complaints, and should not equate to an assumption of inaccuracy of the data.

**Attachment Information:**
The attachment contains relevant excerpts from AHCCCS CYE 2022 MCO contracts, the AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractor Operation Manual (ACOM).
Non-Emergency Medical Transportation: AHCCCS Contract & Policy Requirements

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| ACOM 406, Member Handbook and Provider Directory | Requires that MCOs produce an annually updated member handbook, including language for members about how to obtain NEMT. The MCO must include in its handbook all information in ACOM 406, Attachment A. Attachment A includes: “How to Obtain Medically Necessary Transportation” |
| ACOM Policy 417, Appointment Availability, Transportation Timeliness, Monitoring, and Reporting | “G. Transportation Timeliness Review
For medically necessary non-emergent transportation, the Contractor shall ensure that a member arrives on time for an appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home. The Contractor shall evaluate compliance with the above standards on a quarterly basis for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.” |
| ACOM Policy 417, Transportation Timeliness Deliverable Format | Transportation Timeliness Deliverable Format:
- Total Drop Offs, Timely Drop Offs, % of Timely Drop Offs
- Total Pickups, Timely Pickups, % of Timely Pickups |
| Deliverable Data (Most recently available) | For Contract Year ending 2022, Quarter 1 (Oct-Dec 2021) and Quarter 2 (Jan-Mar 2022) data received on Timeliness of Transportation shows the following:
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### Member Grievances and Quality of Care Concerns

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</table>
enrolled with (for member-specific concerns) and/or the network status of the provider (for systemic provider-related concerns), and then forward all relevant information to the appropriate MCO(s) for review/investigation. A general outline of how concerns are reviewed can be found at the following location: https://www.azahcccs.gov/AHCCCS/Downloads/AHCCCS_IncidentFlowChart_200911.pdf

MCOs document QOC information, including findings and corrective actions, in the AHCCCS Quality Management Portal. AHCCCS selects random samples of completed cases from each MCO and audits the case files (from initial triage through resolution). Additionally, AHCCCS runs data queries on selected procedure codes and assesses for correlating quality of care concern cases; if no case is found, a notification is sent to the MCO for follow up. AHCCCS also monitors timeliness of case review against timelines outlined in AMPM Policy 960; MCOs receive reports on any QOCs that are overdue or at risk of becoming overdue and provide feedback on case status, rationale for extended time frames, and/or corrective action plans for addressing noted issues. If any of the above-mentioned oversight activities show concerning trends or under-performance, findings may result in corrective action, ranging from directed technical assistance, increased monitoring, more detailed audits, Notice to Cure, and/or financial sanctions.

<table>
<thead>
<tr>
<th>AHCCCS Access to Care Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS has an Access to Care Committee which meets quarterly. This cross-divisional committee reviews individual and systemic Access to Care issues for AHCCCS members to inform Medicaid health care delivery decisions, as well as development of rates and reimbursement to ensure availability of AHCCCS-covered services. This Committee reviews member and/or provider complaints, grievances and/or Quality of Care concerns that impact the accessibility and availability of an adequate AHCCCS registered provider network across Arizona.</td>
</tr>
</tbody>
</table>
### Additional Relevant Requirements/Information

| **Contract Language:** Periodic Reporting Requirements | Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions. Standards applied for determining adequacy of required reports are as follows:  
1. **Timeliness:** Reports or other required data shall be received on or before scheduled due dates.  
2. **Accuracy:** Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.  
3. **Completeness:** All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions. |
| **Contract Language:** Administrative Actions | Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, ACOM Policy 408, ACOM Policy 440, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 45, Temporary Management/Operation of a Contractor and Paragraphs 47 through 50 regarding Termination of the Contract. |
| **Strategy to Resolve NEMT Concerns:** AHCCCS NEMT Workgroup | AHCCCS created an Internal NEMT workgroup which meets every six weeks. This cross-divisional team includes staff from the Office of Inspector General, Office of General Counsel, Division of Community Advocacy and Intergovernmental Relations, Division of Member and Provider Services, Division of Health Care Management, Division of Fee For Service Management, and Office of the Director (Legislative Liaison). The Workgroup discusses concerns around NEMT services in general, as well as |
policy and other regulatory changes aimed at improving access to NEMT services. Recent examples include: helping to resolve transportation issues for members residing at the bottom of the Grand Canyon by implementing Equine and Helicopter NEMT options, and new policy language around coverage of public transportation for members.

| Strategy to Resolve NEMT Concerns: MCO Oversight of NEMT Brokers | MCOs meet with NEMT Brokers on a regular basis to review performance, address any gaps in services, and resolve any escalated issues. Additional information reviewed in these meetings include call center statistics, member grievances, complaint resolution reports and timeliness reports.

One recent example regarding MCO work to address gaps in services relates to increasing capacity for specialty transportation (including wheelchair vans). One such idea looked to increase payment rates for providers that service specialty transports. Another looked to give provider incentives to providers who accepted a minimum percentage of rides. |
Summary

This Five-Year Review Report (5YRR) from the Department of Economic Security (Department) relates to rules in Title 6, Chapter 8 regarding Aging and Adult Administration. These rules describe administrative procedures, requirements, and consequences related to Aging and Adult Services.

In the previous 5YRR, for these rules, which the Council approved in 2017, the Department proposed to submit a rulemaking to amend the rules in February 2019. The Department indicates it did not complete the proposed course of action due to COVID-19, which required the Department to expedite the expansion of several existing programs and create new programs, which diverted their staff away from the ongoing rulemaking process. The Department expects to file a Notice of Proposed Rulemaking with the Secretary of State’s Office in September 2022 to amend the rules in Article 1 and in July 2022 to amend the rules in Article 2.

Proposed Action

In this 5YRR, the Department proposes to add definitions to rules in Article 1 to clarify program requirements, address inconsistencies, and make the rules more clear, concise, and
understandable to the public. The Department plans to submit a rulemaking to GRRC in December 2022 to amend the rules in Article 1.

The Department also plans to update the rules in Article 2 by eliminating redundancy, adding definitions, addressing inconsistencies, to make the rules more clear, concise, and understandable to the public. The Department plans to submit a rulemaking to GRRC by November 2022 to amend the rules in Article 2.

1. **Has the agency analyzed whether the rules are authorized by statute?**

   Yes, the Department cites both general and specific statutory authority for the rules.

2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**

   The Department states that no Economic, Consumer, and Small Business Impact Statement (EIS) was prepared for Article 1 when it was last amended in 1993. For Article 2 an EIS was submitted for rulemaking in 2012 and that the rules would have minimal economic impact. The Department believes the estimation submitted in 2012 was accurate and the revised rules have not had a significant impact. Stakeholders include the Department, tribal entities, not-for-profit organizations, governmental organizations, and individuals who engage in or have business with the Aging and Disability Services Administration in the Division of Aging and Adult Services.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   The Department states that through analysis provided by the Department’s program subject matter experts and Financial Services Administration, the Department believes the rules impose the least burden and cost to persons regulated by these rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objectives.

4. **Has the agency received any written criticisms of the rules over the last five years?**

   No, the Department indicates they have not received any written criticisms of the rules over the last five years.

5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**

   Yes, the Department indicates the rules are clear, concise, and understandable with the exception of the following:

   - **R6-8-101:** Definitions
   - **R6-8-108:** Time
   - **R6-8-109:** Scheduling and Notice of Hearing
6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**

Yes, the Department indicates the rules are consistent with other rules and statutes with the exception of the following:

- R6-8-117: Review by the Appeals Board
- R6-8-210: Confidentiality

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**

Yes, the Department indicates the rules are effective in achieving their objectives with the exception of the following:

- R6-8-105: Rights to Appeal
- R6-8-106: Filing an Appeal
- R6-8-107: Service on Parties
- R6-8-109: Scheduling and Notice of Hearing
- R6-8-110: Change of Hearing Officer
- R6-8-112: Subpoena of Witnesses and Documents
- R6-8-114: Hearing Decision
- R6-8-117: Review by the Appeals Board
- R6-8-202: Reporting Requirements for Adult Protective Service Cases
- R6-8-203: Eligibility for Services
- R6-8-205: Classification
- R6-8-206: Investigation
- R6-8-210: Confidentiality

8. **Has the agency analyzed the current enforcement status of the rules?**

Yes, the Department indicates the rules are enforced as written with the exception of the following:

- R6-8-102: Client Complaint Resolution Procedures
- R6-8-103: Right to Review
- R6-8-104: Administrative Review Procedures
- R6-8-111: Failure of a Party to Appear
- R6-8-115: Termination of Appeal
- R6-8-209: Case Closure
9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, the Department indicates the rules are not more stringent than corresponding federal law.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

Not applicable. The Department indicates the rules do not require a permit or license.

11. **Conclusion**

This 5YRR from the Department relates to rules in Title 6, Chapter 8 regarding Aging and Adult Administration. These rules describe administrative procedures, requirements, and consequences related to Aging and Adult Services.

The Department proposes to add definitions to rules in Article 1 to clarify program requirements, address inconsistencies, and make the rules more clear, concise, and understandable to the public. The Department plans to submit a rulemaking to the Council in December 2022 to amend the rules in Article 1.

The Department also plans to update the rules in Article 2 by eliminating redundancy, adding definitions, addressing inconsistencies, to make the rules more clear, concise, and understandable to the public. The Department plans to submit a rulemaking to the Council by November 2022 to amend the rules in Article 2.

Council staff finds the Department submitted a report that meets the requirements of A.R.S. § 41-1056. Council staff recommends approval of this report.
June 28, 2022

Ms. Nicole Sorns in
Council Chair
Governor’s Regulatory Review Council
Department of Administration
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

Dear Ms. Sorns in:

Attached is the Arizona Department of Economic Security (Department) Five-Year Review Report for Arizona Administrative Code (A.A.C.) Title 6, Chapter 8, Aging and Adult Administration. Also attached are copies of the Governor’s Office approval to submit this report, authorizing statutes, and current rules.

Pursuant to A.R.S. § 41-1056(A) and A.A.C. R1-6-301(C)(4), the Department certifies that it is in compliance with A.R.S. § 41-1091.

Thank you for your attention to this report. The Department will be present at the Council meetings to respond to any questions the Council members may have about the report.

If you have any questions, please contact Melissa Henry, Deputy Administrator, Governance and Innovation Administration, at (480) 647-3110.

Sincerely,

Nicole Davis
Office of General Counsel

Attachment
Arizona Department of Economic Security
Five – Year Review Reports

A.R.S. § 41-1056 requires that at least once every five years, each agency shall review its administrative rules and produce reports that assess the rules with respect to considerations including the rule's effectiveness, clarity, conciseness and understandability. The reports also describe the agency’s proposed action to respond to any concerns identified during the review. The reports are submitted in compliance with the schedule provided by the Governor’s Regulatory Review Council (GRRC). A.R.S. § 18-305, enacted in 2016, requires that statutorily required reports be posted on the agency's website.
1. **Authorization of the rule by existing statutes**


2. **The objective of each rule**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-101</td>
<td>The objective of this rule is to define terms used in Chapter 8.</td>
</tr>
<tr>
<td>R6-8-102</td>
<td>The objective of this rule is to describe area agency complaint resolution processes, including requirements for the contents of written procedures and allotted timeframes.</td>
</tr>
<tr>
<td>R6-8-103</td>
<td>The objective of this rule is to explain when an administrative review is available.</td>
</tr>
<tr>
<td>R6-8-104</td>
<td>The objective of this rule is to describe the processes and requirements for an administrative review.</td>
</tr>
<tr>
<td>R6-8-105</td>
<td>The objective of this rule is to describe the right to file an appeal of the Department's final decision.</td>
</tr>
<tr>
<td>R6-8-106</td>
<td>The objective of this rule is to describe the process that a client or grievant follows to file an appeal described in R6-8-105.</td>
</tr>
<tr>
<td>R6-8-107</td>
<td>The objective of this rule is to explain when a document is considered to be served on a party.</td>
</tr>
<tr>
<td>R6-8-108</td>
<td>The objectives of this rule are to clarify the meaning of “days” and explain how the Department computes time for purposes of this Article.</td>
</tr>
<tr>
<td>R6-8-109</td>
<td>The objectives of this rule are to describe how hearings are scheduled and by whom, describe how the Department gives notice of a hearing to the parties, and explain that a party may request postponement of a hearing if the party has good cause for doing so.</td>
</tr>
<tr>
<td>R6-8-110</td>
<td>The objective of this rule is to explain when and how a party may request a change of hearing officer.</td>
</tr>
<tr>
<td>R6-8-111</td>
<td>The objectives of this rule are to explain the consequences for a party’s failure to appear for a hearing and that a party may request to reopen a hearing when there was good cause for the failure to appear.</td>
</tr>
<tr>
<td>R6-8-112</td>
<td>The objectives of this rule are to describe the requirements for a party to request that the hearing officer issue a subpoena for witnesses or</td>
</tr>
</tbody>
</table>
documents and to specify how the Department serves all subpoenas.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-113</td>
<td>The objective of this rule is to describe how the Department conducts a hearing including the role of the hearing officer, guidance about evidence, and creation of the hearing record.</td>
</tr>
<tr>
<td>R6-8-114</td>
<td>The objectives of this rule are to explain how the Department issues a hearing decision to each party, to identify the contents of a hearing decision, and to specify the applicability and finality of a hearing decision.</td>
</tr>
<tr>
<td>R6-8-115</td>
<td>The objectives of this rule are to describe how to terminate an appeal, either voluntarily or by default.</td>
</tr>
<tr>
<td>R6-8-116</td>
<td>The objectives of this rule are to describe when an appellant may file an appeal to the Commissioner on Aging with the U.S. Department of Health and Human Services (HHS), the timeframe for an appeal to HHS, and the method by which an appeal is made.</td>
</tr>
<tr>
<td>R6-8-117</td>
<td>The objectives of this rule are to describe when a petition for review of an adverse hearing decision may be made to the Appeals Board, the timeframe for appeal to the Appeals Board, the method by which an appeal is made, and the requirements regarding an Appeals Board decision.</td>
</tr>
</tbody>
</table>

**Article 2**

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-201</td>
<td>The objective of this rule is to define terms used in Article 2.</td>
</tr>
<tr>
<td>R6-8-202</td>
<td>The objective of this rule is to identify what information Adult Protective Services (APS) is required to obtain from a reporting source.</td>
</tr>
<tr>
<td>R6-8-203</td>
<td>The objective of this rule is to explain who is eligible for APS.</td>
</tr>
<tr>
<td>R6-8-204</td>
<td>The objective of this rule is to specify where an APS worker may and may not investigate a report.</td>
</tr>
<tr>
<td>R6-8-205</td>
<td>The objective of this rule is to explain that APS workers classify incoming communication as either “information and referral” or as “a report accepted for evaluation and investigation”.</td>
</tr>
<tr>
<td>R6-8-206</td>
<td>The objective of this rule is to describe when and how APS investigates a report of abuse, neglect, or exploitation of a vulnerable adult.</td>
</tr>
<tr>
<td>R6-8-207</td>
<td>The objectives of this rule are to describe the contents of an APS case plan and the responsibilities of an APS worker in creating and maintaining the case plan for an APS client.</td>
</tr>
<tr>
<td>R6-8-208</td>
<td>The objective of this rule is to explain an adult's and a guardian’s right to refuse adult protective services and actions the Department may take if an APS worker believes services are necessary and either the adult needs, but does not have, a guardian or the adult’s guardian is not acting in the adult’s best interest.</td>
</tr>
<tr>
<td>R6-8-209</td>
<td>The objective of this rule is to explain the circumstances under which the Department may close a case.</td>
</tr>
<tr>
<td>R6-8-210</td>
<td>The objectives of this rule are to explain how the Department ensures confidentiality of APS information in accordance with A.R.S. § 41-1959</td>
</tr>
</tbody>
</table>
A.R.S. § 41-1959(C) to request confidential information.

3. **Are the rules effective in achieving their objectives?**

   Yes ☐  No ☒

   *If not, please identify the rule(s) that is not effective and provide an explanation for why the rule(s) is not effective.*

<table>
<thead>
<tr>
<th>Rule</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-105</td>
<td>This rule is ineffective in meeting the objectives because the rule does not indicate that a client or applicant may file an appeal with the Department's Office of Appeals.</td>
</tr>
<tr>
<td>R6-8-106</td>
<td>This rule is ineffective in meeting the objectives because the rule does not reflect the current practices and requirements for filing an appeal.</td>
</tr>
<tr>
<td>R6-8-107</td>
<td>This rule is ineffective in meeting the objectives because the rule does not reflect the current process for how the Department serves parties.</td>
</tr>
<tr>
<td>R6-8-109</td>
<td>This rule is ineffective in meeting the objectives because the rule does not clearly state by what methods a party may submit documents to the Department.</td>
</tr>
<tr>
<td>R6-8-110</td>
<td>This rule is ineffective in meeting the objectives because the rule does not provide adequate information regarding when a party may request a change of hearing officer.</td>
</tr>
<tr>
<td>R6-8-112</td>
<td>This rule is ineffective in meeting the objectives because the rule does not provide adequate information for how or when a subpoena for a witness or document is issued by a hearing officer.</td>
</tr>
<tr>
<td>R6-8-114</td>
<td>This rule is ineffective in meeting the objectives because information regarding how the Department may reschedule or continue a hearing is not currently addressed.</td>
</tr>
<tr>
<td>R6-8-117</td>
<td>This rule is ineffective in meeting the objective because the rule does not address what kinds of decisions the Appeals Board can make.</td>
</tr>
<tr>
<td>R6-8-202</td>
<td>This rule is ineffective in meeting the objectives because the reporting requirement for APS cases is vague.</td>
</tr>
<tr>
<td>R6-8-203</td>
<td>This rule is ineffective in meeting the objectives because the criteria for eligibility in the APS program are vague.</td>
</tr>
<tr>
<td>R6-8-205</td>
<td>This rule is ineffective in meeting the objectives because it does not clearly state how the Department determines whether incoming information constitutes a communication for information and referral or qualifies as a report that is accepted for evaluation and investigation.</td>
</tr>
<tr>
<td>R6-8-206</td>
<td>This rule is ineffective in meeting the objectives because the rule contains too much detail and is too rigid to allow APS to adapt investigation methods to changing community standards, best practices,</td>
</tr>
</tbody>
</table>
and available resources.

R6-8-210 This rule is ineffective in meeting the objectives because the information regarding confidentiality is obsolete due to legislative changes found in A.R.S. § 14-1959 and the addition of A.R.S § 46-460.

4. **Are the rules consistent with other rules and statutes?**
   - Yes ☐
   - No ☒

   *If not, please identify the rule(s) that is not consistent. Also, provide an explanation and identify the provisions that are not consistent with the rule.*

<table>
<thead>
<tr>
<th>Rule</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 1</td>
<td>The rule is inconsistent with statute because A.R.S. § 41-1992(C) and (D) currently states that the Appeals Board may hear any adverse decision issued by a hearing officer, whereas the current rule does not communicate this information.</td>
</tr>
<tr>
<td>R6-8-210</td>
<td>This rule is inconsistent with statute because subsections (A) and (B) refer to A.R.S. § 41-1959, which no longer applies to APS. Instead, A.R.S § 46-460 now governs the confidentiality and allowable disclosure of confidential information regarding any person involved with APS. Although the citation in subsection (B) of this rule is incorrect, the content of subsection (B) regarding the process for requesting confidential information is consistent with A.R.S § 46-460.</td>
</tr>
</tbody>
</table>

5. **Are the rules enforced as written?**
   - Yes ☐
   - No ☒

   *If not, please identify the rule(s) that is not enforced as written and provide an explanation of the issues with enforcement. In addition, include the agency’s proposal for resolving the issue.*

<table>
<thead>
<tr>
<th>Article 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-102</td>
<td>This rule is not enforced as written because this rule only requires each area agency to maintain complaint resolution procedures. Current DES practice requires each area agency to maintain policy and procedures for filing, resolving, and appealing complaints by applicants and clients. Current practice also requires each area agency to provide written notification to an applicant or client regarding their rights and applicable procedures concerning complaints and appeals. The Department proposes to amend this rule to clarify that each area agency shall have written policies and procedures for filing, resolving, and appealing complaints and providing written notification to an applicant or client regarding rights and procedures concerning complaints and appeals.</td>
</tr>
</tbody>
</table>
| R6-8-103  | This rule is not enforced as written because it does not align with the current practice of trying to resolve an applicant’s or client’s complaint against a service provider informally at the level at which an incident occurred. This rule also does not address an applicant’s or client’s right to elevate the complaint about a service provider to the area agency if
A response isn't received from a service provider or the client or applicant is dissatisfied with the informal resolution. The Department proposes to amend this rule and revise language to include procedures for filing a complaint with a service provider for informal resolution and the process for elevating the complaint about a service provider to the area agency if a response isn't received from a service provider or the client or applicant is dissatisfied with the informal resolution.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-104</td>
<td>This rule is not enforced as written because the rule currently states a request for an administrative review from a grievant or grievant representative is directed to the Program Administrator, whereas a grievance or complaint currently goes directly to the Department's Office of Appeals. The Department proposes to amend this rule to reflect current practice.</td>
</tr>
<tr>
<td>R6-8-111</td>
<td>This rule is not enforced as written because the rule does not reflect all of the options a hearing officer has when a party fails to appear for a hearing. The Department proposes to amend this rule to clarify that the hearing officer may either make a decision in a party's absence or dismiss the appeal when a party fails to appear. The Department also proposes to add language regarding a hearing to determine whether a party had good cause for failure to appear when the party requests to reopen an appeal.</td>
</tr>
<tr>
<td>R6-8-115</td>
<td>This rule is not enforced as written because the Department's Office of Appeals will now accept an oral or written request for withdrawal of an appeal. The Department proposes to repeal this rule because the Department no longer requires a written request to withdraw a request for hearing.</td>
</tr>
<tr>
<td>Article 2</td>
<td>This rule is not enforced as written because the reasons for closing an APS case do not align with current practice. For example, the Department does not close a case when a client moves out of jurisdiction, it continues the investigation, especially if the alleged perpetrator is still in APS jurisdiction and may cause potential harm to others. APS also finishes the investigation when a client is admitted to a state institution or other care facility and completes the case plan. The Department proposes to repeal this rule and address reasons for closing a case in program policy.</td>
</tr>
</tbody>
</table>

6. **Are the rules clear, concise, and understandable?**  
   Yes ☐  No ☒

*If not, please identify the rule(s) that is not clear, concise, or understandable and provide an explanation as to how the agency plans to amend the rule(s) to improve clarity, conciseness, and understandability.*

<table>
<thead>
<tr>
<th>Rule</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 1</td>
<td>This rule is not clear, concise, or understandable, because the definitions include outdated terminology and some terms are not defined. The</td>
</tr>
</tbody>
</table>
Department proposes to amend this rule by removing terms that are no longer used, adding terms that are currently used, adding an index for easy location of definitions, and revising language throughout to ensure it is easier to understand.

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R6-8-108</td>
<td>This rule is not clear, concise, or understandable as written because the rule describes how the Department calculates time using confusing and outdated language. In addition, the rule fails to specify when the Department is required to calculate time. The Department proposes to amend this rule by revising language so that it clearly and concisely explains how the Department computes time in relation to a grievance or hearing.</td>
</tr>
<tr>
<td>R6-8-109</td>
<td>This rule is not clear, concise, or understandable as written because the rule attempts to address too many topics and includes passive voice, difficult language, and overly complex sentence structure. The Department proposes to amend this rule by revising language so that it is easier to understand.</td>
</tr>
<tr>
<td>R6-8-113</td>
<td>This rule is not clear, concise, or understandable as written because the rule attempts to address too many topics and includes passive voice and overly complex sentence structure. The Department proposes to amend this rule by revising language so that it is easier to understand.</td>
</tr>
<tr>
<td>Article 2</td>
<td></td>
</tr>
<tr>
<td>R6-8-201</td>
<td>This rule is not clear, concise, or understandable, as the rule's definitions include outdated terminology and are not in alphabetical order. The Department proposes to amend this rule by alphabetizing definitions, removing terms that are no longer used, adding terms that are currently used, adding an index for easy location of definitions, and revising language throughout to ensure it is easier to understand.</td>
</tr>
<tr>
<td>R6-8-208</td>
<td>This rule is not clear, concise, or understandable because the rule uses overly complex sentence structure. The Department proposes to amend this rule by revising language so that it is easier to understand.</td>
</tr>
</tbody>
</table>

7. **Has the agency received written criticisms of the rules within the last five years?**
   
   ![Yes](☐) ![No](☒)

   *If yes, please fill out the table below:*

<table>
<thead>
<tr>
<th>Commenter</th>
<th>Comment</th>
<th>Agency’s Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

8. **Economic, small business, and consumer impact comparison:**
   **Article 1**

   To the Department's knowledge, no Economic Impact Statement was prepared for Article 1 when it was last amended in 1993.
Currently, there are eight area agencies in Arizona; two are tribal entities, three are not-for-profit organizations, and three are governmental organizations. 11 FTEs work in the Aging and Disability Services Administration in the Division of Aging and Adult Services, including one Program Administrator, two Program Managers, five Program Coordinators, and three Program and Project Specialists.

For State Fiscal Year (SFY) 2022, area agencies have received a total of $91,083,248 in funding from the Supporting Older Americans Act ($65,243,898.00), Social Service Block Grant ($12,918,926.00), State of Arizona ($11,910,800.00) and Discretionary grants ($1,009,624.00).

**Article 2**

In an Economic Impact Statement that was submitted with the Notice of Final Rulemaking for Article 2 in 2012, the Department estimated that the rules in Article 2 would have minimal economic impact. The estimation submitted in 2012 was accurate and the revised rules have not had a significant cost impact.

APS has experienced year over year growth in new reports of abuse, neglect, and exploitation with new report growth for SFY 2021 above 17 percent year over year and projected to be at or just above 25 percent in SFY 2022 and 30 percent in SFY 2023. This breaks down to a projected 29,575 new reports in SFY 2022 and 38,448 in SFY 2023. In SFY 2022, the average caseload per investigator, as of May 2022, was 1:57. As of April 2022, APS has a total of 276 FTEs, of which 238 are field staff, 21 Central Intake Unit staff, and 14 are Quality Assurance and Policy staff.

9. **Has the agency received any business competitiveness analyses of the rules?**
   
   Yes ☐ No ☒
   
   The Department did not receive a business competitive analysis of these rules.

10. **Has the agency completed the course of action indicated in the agency's previous five-year review report?**
    
    Yes ☐ No ☒
    
    Please state what the previous course of action was and if the agency did not complete the action, please explain why not.

**Article 1**

The Department indicated in the 2017 Five-Year Review Report that it anticipated submitting a Notice of Final Rulemaking to the Governor’s Regulatory Review Council (GRRC) for
Article 2 in February 2019. The Department received an exception to the rulemaking moratorium from the Governor's Office on December 18, 2019. The COVID-19 Pandemic that began in early 2020 forced the Department's Division of Aging and Adult Services (DAAS) to shift resources to pandemic response efforts. The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan Act (ARPA) of 2021 provided DAAS with over $711 million in new funding, which was used to expedite the expansion of several existing programs and creation of large new programs to meet the urgent needs of Arizonans including the Emergency Rental Assistance Program (ERAP) and the Low Income Household Water Assistance Program (LIHWAP). These new and expanded programs required frequent drafting and revision of applicable policies and guidance which diverted staff away from the ongoing rulemaking process. As the pandemic has waned and staff availability stabilized, the Department renewed its commitment to rulemaking and made significant progress on these rules. The Department engaged in informal stakeholder input for the draft rules in January 2022. The Department expects to file a Notice of Proposed Rulemaking with the Secretary of State's Office in September 2022.

**Article 2**

The Department indicated in the 2017 Five-Year Review Report that it anticipated submitting a Notice of Final Rulemaking to GRRC for Article 2 in February 2019. The Department received an exception to the rulemaking moratorium from the Governor's Office on September 24, 2018. However, at the beginning of the 2019 legislative session, the Department put this rulemaking on hold to address the significant statutory changes to APS that became effective August 27, 2019. When work on the APS rules resumed and the new laws were being incorporated into the rules, progress was further delayed by the COVID-19 pandemic as noted above, organizational changes within DES, staffing changes, and shifting of priorities. Similarly to Article 1, described above, the Department made marked progress on these rules. The Department engaged in informal stakeholder input for the draft rules in January 2022 and expects to file a Notice of Proposed Rulemaking with the Secretary of State's Office in July 2022.

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**

Through analysis provided by the Department’s program subject matter experts and Financial
Services Administration, the Department has determined that the rules impose the least burden and cost to persons regulated by these rules, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objectives. There are no fees associated with these rules.

**Article 1**

This Article governs complaint and appeal processes for services funded under a federally-approved Area Plan on Aging, including complaints and appeals related to service providers and Area Agencies on Aging.

Program subject matter experts indicate that the proposed amendments to the rules identified in this report are the most cost-effective way to ensure compliance with the federal Older Americans Act, other federal statutes and regulations, and state statutes, as well as to ensure that the rules reflect current and best practices. These rules do not impose any costs to the Department or persons governed by the rules, although there may be some costs associated with addressing a complaint or appeal. Amendments proposed in this report would not increase these costs or the paperwork required for compliance.

Without these rules, there would be no clear mechanism to address complaints against service providers or Area Agencies on Aging. These rules are necessary to protect the rights of individuals who are entitled to services under the federal Older Americans Act and other federal and state laws, as well as the rights of small businesses seeking to provide services under these laws. The benefit of having clear and understandable rules about the complaint and appeal process outweigh any costs.
Article 2

This Article governs APS, which performs the critical role of investigating allegations of abuse, exploitation, and neglect of vulnerable adults in Arizona and providing those Arizonans with valuable services.

Program subject matter experts indicate that the proposed amendments to the rules identified in this report are the most cost-effective way to comply with state statutes and ensure that the rules reflect recent legislative changes and current program practice. The proposed amendments do not impose any new costs to the Department, other state agencies, or persons regulated by these rules.

Without these rules, there would be no clear system to perform the essential function of protecting Arizona’s vulnerable adults. Revisions proposed in this report will provide clearer rules about the processes APS uses for receiving and evaluating allegations, as well as more effective language about how APS conducts investigations and provides service referrals. The benefit of having comprehensive rules to protect vulnerable adults outweigh any costs associated with those rules.

12. **Are the rules more stringent than corresponding federal laws?**  
   Yes ☐  
   No ☒

*Please provide a citation for the federal law(s). And if the rule(s) is more stringent, is there statutory authority to exceed the requirements of federal law(s)?*

**Article 1:** Older Americans Act of 1965, as amended (42 U.S.C. 3001 et. seq);  

**Article 2:** NA

13. **For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:**

   The Department has determined that A.R.S. § 41-1037 does not apply to these rules, because the Department is not proposing a new rule or an amendment to an existing rule
that requires the issuance of a regulatory permit, license, or Department authorization.

14. **Proposed course of action:**

*If possible, please identify a month and year by which the agency plans to complete the course of action.*

**Article 1**

The Department received a moratorium exception request from the Governor's Office in December 2019 for approval to engage in regular rulemaking to update Article 1 to include updated grievance procedures. The regular rulemaking will also add definitions of terms used in Article 1, clarify program requirements to resolve complaints related to the provision of the Supporting Older Americans Act programs, address inconsistencies within the Article, and make the rules more clear, concise, and understandable to the public. The Department engaged in informal stakeholder input for the draft rules in January 2022, and the Department expects to file a Notice of Proposed Rulemaking with the Secretary of State's Office in September 2022. The Department anticipates submitting a Notice of Final Rulemaking to GRRC in December 2022.

**Article 2**

The Department received a moratorium exception request from the Governor's Office in September 2018 for approval to engage in regular rulemaking to update Article 2 to eliminate redundancy regarding eligibility for APS services and jurisdiction and to add content regarding the rights of vulnerable adults and alleged perpetrators in the services provided by APS. The regular rulemaking will also add definitions of terms used in Article 2, address inconsistencies within the Article, and make the rules more clear, concise, and understandable to the public. The Department engaged in informal stakeholder input for the draft rules in January 2022. The Department expects to file a Notice of Proposed Rulemaking with the Secretary of State's Office in July 2022 and submit a Notice of Final Rulemaking to GRRC in November 2022.
ARTICLE 1. GRIEVANCES AND HEARINGS

Article 1, consisting of Sections R6-8-101 through R6-8-117, adopted effective August 9, 1993 (Supp. 93-3).

Article 1, consisting of Sections R6-8-101 through R6-8-111, repealed effective August 9, 1993 (Supp. 93-3).

Article 1, consisting of Sections R6-8-101 through R6-8-111, adopted effective May 12, 1981 (Supp. 81-3).

ARTICLE 2. ADULT PROTECTIVE SERVICES

Article 2, consisting of Sections R6-8-201 through R6-8-210, adopted effective August 21, 1996 (Supp. 96-3).

Article 2, consisting of Sections R6-8-201 through R6-8-224, repealed effective August 21, 1996 (Supp. 96-3).

Article 2, consisting of Sections R6-8-201 through R6-8-224, recodified from A.A.C. R6-5-5601 through R6-5-5624 effective February 13, 1996 (Supp. 96-1).

Section
R6-8-101. Definitions
R6-8-102. Client Complaint Resolution Procedures
R6-8-103. Right to Review
R6-8-104. Administrative Review Procedures
R6-8-105. Right to Appeal
R6-8-106. Filing an Appeal
R6-8-107. Service on Parties
R6-8-108. Time
R6-8-109. Scheduling and Notice of Hearing
R6-8-110. Change of Hearing Officer
R6-8-111. Failure of a Party to Appear
R6-8-112. Subpoena of Witnesses and Documents
R6-8-113. Conduct of Hearing
R6-8-114. Hearing Decision
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R6-8-201. Definitions
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R6-8-203. Eligibility for Services
R6-8-204. Jurisdiction
R6-8-205. Classification
R6-8-206. Investigation
R6-8-207. Case Planning
R6-8-208. Refusal of Services by the Adult or Guardian
R6-8-209. Case Closure
R6-8-210. Confidentiality
R6-8-211. Repealed
R6-8-212. Repealed
R6-8-213. Repealed
R6-8-214. Repealed
R6-8-215. Repealed
R6-8-216. Repealed
R6-8-217. Repealed
R6-8-218. Repealed
R6-8-219. Repealed
R6-8-220. Repealed
R6-8-221. Repealed
R6-8-222. Repealed

ARTICLE 1. GRIEVANCES AND HEARINGS

R6-8-101. Definitions
A. “Aging and Adult Administration” means the Aging and Adult Administration of the Division of Aging and Community Services, Department of Economic Security.
B. “Area agency” means an organization designated by the Department to develop and administer the area plan for a system of services to older persons.
C. “Area plan” means a plan for a comprehensive and coordinated system of services for older persons governing activities in a planning and service area.
D. “Client” means any person who applies for or receives services from the Department or from a service provider under the Older Americans Act, 42 U.S.C. 3001 et seq. or the Arizona Older Americans Act - nonmedical Home and Community-Based Care Services, A.R.S. § 46-191 et seq.
E. “Department” means the Department of Economic Security.
F. “Grievant” means an organization listed in R6-8-103 which has filed a request for review with the Department.
G. “Nutrition project” means the recipient of a subgrant or contract to provide nutrition services, other than the Area Agency.
H. “Party” means any client or grievant appealing an action under R6-8-105 or the Department.
I. “Program Administrator” means the Administrator of the Aging and Adult Administration.
J. “Service provider” means a person or organization that is awarded a subgrant or contract from an area agency to provide services under the area plan.

Historical Note
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-102. Client Complaint Resolution Procedures

A. Each area agency shall have a written complaint resolution procedure which shall be made available to all clients.
B. The complaint resolution procedure shall provide for an informal meeting to adjust the dispute and shall inform the client of the right to appeal if not satisfied with the area agency’s decision.
C. The area agency shall issue its decision within 30 days of the date the complaint is filed.

Historical Note
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

R6-8-103. Right to Review

An administrative review shall be available to:

1. Any area agency when the Department proposes to disapprove an area plan or plan amendment submitted by the area agency, or withdraw the area agency’s designation;
2. Any applicant for designation as a planning and service area whose application is denied;
3. Any nutrition project for which the area agency proposes to cancel funding;
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4. Any service provider whose application to provide services under an area plan is denied or whose subgrant or contract is terminated or not renewed.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-104. Administrative Review Procedures**

A. A request for administrative review must be filed in writing within 30 days of receipt of the notice of an adverse action. The request shall be signed by the grievant or an authorized representative of the grievant and directed to:
   - The Program Administrator
   - Aging and Adult Administration
   - Department of Economic Security
   - P.O. Box 6123
   - Phoenix, Arizona 85005

B. The Program Administrator or the Administrator’s designee shall schedule an administrative review conference to meet with the grievant or a representative of the grievant. At the administrative review conference, the grievant or the grievant’s representative may review pertinent evidence on which the action was based.

C. The Program Administrator shall issue a final decision within 60 days of the filing of the request for administrative review.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-105. Right to Appeal**

A. A client who is dissatisfied with the final decision issued by the area agency pursuant to R6-8-102 of this Article has the right to appeal that decision.

B. A grievant who is dissatisfied with the final decision issued by the Program Administrator pursuant to R6-8-103 of this Article has the right to appeal that decision.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-106. Filing an Appeal**

A. Any client or grievant filing an appeal under these rules shall file a written request for hearing with the Program Administrator within 15 days after the mailing date of the area agency or Program Administrator’s decision.

B. A document shall be considered received by and filed with the Department:
   1. If transmitted via the United States Postal Service, on the date it is mailed. The mailing date shall be:
      a. As shown by the postmark; or
      b. As shown by the postage meter mark of the envelope in which it is received if there is no postmark; or
      c. The date entered on the document as the date of its completion, if there is no postmark, or no postage meter mark, or if the mark is illegible.
   2. On the date it is received by the Department, if transmitted by any means other than the United States Postal Service.
   3. The submission of document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the Department that the delay in submission was due to Department error or misinformation, or to delay by the United States Postal Service.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-107. Service on Parties**

Any document mailed by the Department shall be considered as having been served on the addressee on the date it is mailed to the addressee’s last known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated by the facts.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-108. Time**

Any reference within this Article to “days” shall mean calendar days unless otherwise specified. In computing any period of time, the date of the act, event, or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be counted, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-109. Scheduling and Notice of Hearing**

A. Hearings shall be held at those regularly established hearing locations most convenient to the parties or, at the discretion of the hearing officer, by telephone. The parties shall be given no less than 20 days’ notice of hearing, except that the parties may waive the notice period or request a delay.

B. The notice of hearing shall inform the parties of the date, time, and place of hearing, the name of the hearing officer, the issues involved, and the right to:
   1. Present the case in person or by telephone.
   2. Copy any documents to be used by the Department at the hearing at a reasonable time before the hearing.
   3. Request a change of hearing officer.

C. If a party contacts the Office of Appeals promptly after receiving the notice of hearing and requests a postponement for good cause, the hearing officer shall grant a postponement for a reasonable period. Good cause exists when the circumstances causing the request are beyond the reasonable control of the requesting party and failure to grant the postponement would result in undue hardship to the requesting party.

D. All scheduling is the responsibility of the Office of Appeals.

**Historical Note**
Adopted effective May 12, 1981 (Supp. 81-3). Section repealed, new Section adopted effective August 9, 1993 (Supp. 93-3).

**R6-8-110. Change of Hearing Officer**

Not less than five days before the date set for the hearing, any party may file a written request for change of hearing officer and the matter shall immediately be transferred to another hearing officer. A hearing officer may be challenged for cause at any time before a decision becomes final. Except for good cause, not more than one change of hearing officer shall be granted to any one party.
At the conclusion of the hearing, the parties shall be granted an opportunity to present oral argument, or to file briefs, or both.

H. A full and complete record shall be kept of all proceedings in connection with an appeal. The record shall be open for inspection by the parties. A transcript of the proceedings need not be made unless it is required for further proceedings.

R6-8-114. Hearing Decision
A. A hearing decision shall be rendered exclusively on the evidence and testimony produced at the hearing, appropriate state and federal law, and Department rules governing the issue in dispute.
B. The decision shall set forth the pertinent facts involved, the conclusions drawn from such facts, the sections of applicable law or rule, the decision, and the reasons therefor. A copy of the decision, together with an explanation of the appeal rights, shall be delivered or mailed to each party or designated representative not more than 60 days from the date of filing the request for hearing unless the delay was caused by the appellant, in which case the time limit for delivery is extended by the number of days attributable to the appellant.

C. All decisions in favor of the appellant apply retroactively to the date of the action being appealed or to the date the hearing officer specifically finds appropriate.
D. The decision of the hearing officer shall become the final decision if the appeal is not timely filed.

R6-8-115. Termination of Appeal
An appeal may be terminated as follows:
1. By voluntary withdrawal if the appellant submits a signed letter or on the record at any time before the hearing decision is issued.
2. By default when a party fails to appear at a scheduled hearing and fails to request a rescheduled hearing within 15 days. An appeal will not be considered abandoned if the party provides notification up to the time of the hearing that he is unable, due to good cause, to appear and that he still wishes a hearing, or that the matter be considered on the record.

R6-8-116. Appeal to the Commissioner on Aging
A. An appellant which has been denied designation as a planning and service area may appeal to the Commissioner on Aging, Department of Health and Human Services, within 30 days after the hearing officer’s decision is mailed or otherwise delivered.
B. The appeal shall be in writing, signed, and dated. It shall set forth the grounds for the request and may be filed personally or by mail to the Administrator, Aging and Adult Administration.

R6-8-117. Review by the Appeals Board
A. In all cases not covered by R6-8-116 of this Article, a party may petition for review of an adverse hearing decision within 15 days after the decision is mailed or otherwise delivered to the appellant. The petition for review shall be in writing.
signed, and dated. It shall state the grounds for the request and may be filed personally or by mail to the Aging and Adult Administration or the Office of Appeals.

B. The Appeals Board may remove to itself any matter before a hearing officer before the issuance of a decision or, if a decision has been issued, before the decision has become final. Upon removal, the Appeals Board shall notify the parties of the removal.

C. In any case of removal or review, the Appeals Board shall notify the Office of Appeals that it has accepted jurisdiction, and the Office of Appeals shall prepare a complete record of the case, including a transcript, which shall be provided to the parties upon request.

D. A copy of the Appeals Board decision, together with a statement specifying the rights to further review, shall be distributed to each party.

Historical Note
Adopted effective August 9, 1993 (Supp. 93-3).

ARTICLE 2. ADULT PROTECTIVE SERVICES

R6-8-201. Definitions
In addition to the definitions in A.R.S. § 46-451, the following definitions apply in this Article unless the context requires otherwise.

1. “Adult” means a person 18 years of age or older.

2. “Adult Protective Services” or “APS” means a program within the Department of Economic Security which provides protective services.

3. “Conservator” means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5401 et seq.

4. “Danger to self” means:
   a. Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual’s previous acts, it is substantially supportive of an expectation that the threat will be carried out; {or}
   b. Behavior which, as a result of a mental disorder, will, without hospitalization, result in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled. A.R.S. § 36-501(5).


6. “Gravely disabled” means “a condition, evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm, or serious illness because he is unable to provide for his basic physical needs.” A.R.S. § 36-501.

7. “Guardian” means a person who has been appointed by a court to manage the affairs of another, as prescribed in A.R.S. § 14-5310.01 et seq.

8. “Information and referral” means the provision of information or referral to help a person who contacts or is reported to the Department, but is not alleged to be abused, neglected, or exploited, to locate and obtain help with a problem.

9. “Intake” means a duty performed by APS staff in receiving reports or providing information and referral.

10. “Jurisdiction” means the state of Arizona, exclusive of Native American Reservation land.

11. “Life-threatening situation” means a situation or circumstance that is likely to result in death if not corrected by medical or law enforcement intervention.

12. “Mental disorder” means “a substantial disorder of a person’s emotional processes, thought, cognition, or memory. Mental disorder is distinguished from:
   a. Conditions which are primarily those of drug abuse, alcoholism, or mental retardation, unless, in addition to 1 or more of these conditions, the person has a mental disorder;
   b. The declining mental abilities that directly accompany impending death; and
   c. Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder.” A.R.S. § 36-501.

13. “Personally identifiable information” means any information that can indicate a person’s identity including:
   a. Name;
   b. Address;
   c. Telephone number;
   d. Fax number;
   e. Photograph;
   f. Fingerprints;
   g. Physical description;
   h. Place, address, or telephone number of employment;
   i. Social security number;
   j. Tribal affiliation;
   k. Tribal identification number;
   l. Driver’s license number;
   m. Birthdate;
   n. Medical information, history, and diagnosis; or
   o. Any other information that would reasonably lead to the identification of a person.

14. “Prepetition screening” means the “review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services.” A.R.S. § 36-501(30).

15. “Protected person” means “a minor or any other person for whom a conservator has been appointed or any other protective order has been made”. A.R.S. § 14-5101(4).

16. “Protective services” means “a program of identifiable and specialized social services that may offer social services appropriate to resolve problems of abuse, exploitation or neglect of an incapacitated or vulnerable adult”. A.R.S. § 46-451(A)(8).

17. “Record” means a collection of documents, including electronic documents, related to casework about a person reported to APS, or receiving APS services.

18. “Report” means a communication which alleges abuse, neglect, or exploitation of an incapacitated or vulnerable adult, or information regarding an adult who may be in need of protective services.

19. “Special visitation warrant” means an order of the Superior Court that is issued as prescribed in A.R.S. § 14-5310.01 and which permits an APS worker, accompanied by a peace officer, to visit the residence of an adult
believed to be incapacitated and abused, neglected, or exploited.
20. “Business day” means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding Arizona state holidays.

**Historical Note**
R6-8-201 recodified from A.A.C. R6-5-5601 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-201 repealed, new Section R6-8-201 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

**R6-8-202.** Reporting Requirements for Adult Protective Service Cases
Upon receipt of a report, as prescribed in A.R.S. § 46-454, APS shall ask the reporting source to provide:

1. All information as prescribed in A.R.S. § 46-454(C); and,
2. As much information regarding the allegedly incapacitated, or vulnerable adult as is available to the source including:
   a. The names and addresses of those involved and their roles;
   b. The length of time the situation has been ongoing;
   c. The client’s functional level;
   d. Whether other agencies are providing assistance and, if so, what type of assistance; and,
   e. Any other information that may assist the APS worker in the investigation.

**Historical Note**
R6-8-202 recodified from A.A.C. R6-5-5602 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-202 repealed, new Section R6-8-202 adopted effective August 21, 1996 (Supp. 96-3).

**R6-8-203.** Eligibility for Services
To be eligible for APS services, a person shall be:

1. Age 18 years or older;
2. Incapacitated or vulnerable;
3. The victim or alleged victim of abuse, neglect, or exploitation; and,
4. Within the jurisdiction.

**Historical Note**
R6-8-203 recodified from A.A.C. R6-5-5603 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-203 repealed, new Section R6-8-203 adopted effective August 21, 1996 (Supp. 96-3).

**R6-8-204.** Jurisdiction
A. An APS worker shall not investigate reports of events that occurred in another state or foreign country.
B. An APS worker shall investigate reports that occurred on an Indian reservation, upon written invitation by the tribal council.

**Historical Note**
R6-8-204 recodified from A.A.C. R6-5-5604 effective February 13, 1996 (Supp. 96-1). Former Section R6-8-204 repealed, new Section R6-8-204 adopted effective August 21, 1996 (Supp. 96-3). Amended by final rulemaking at 18 A.A.R. 2716, effective December 2, 2012 (Supp. 12-4).

**R6-8-205.** Classification
At intake, an APS worker shall classify the incoming communication into one of the following two categories:

1. Information and referral, or
2. Report accepted for evaluation and investigation.
A. The APS worker shall maintain a case plan for clients in need of protective services.
   1. The case plan shall contain:
      a. Specific goals and objectives,
      b. Outline of casework activities for achieving objectives, and,
      c. Time frames for achieving objectives.

B. An APS worker shall:
   1. Involve the client in identifying and understanding the client's needs and planning of services to address those needs, unless the client’s mental or physical condition prevents the client from participating in planning;
   2. Locate persons who can help the client achieve planned goals;
   3. Regularly assess the client’s progress towards the goals;
   4. Revise goals to meet the changing needs of the client; and,
   5. Coordinate with other agencies to address the client’s needs.

C. The person shall send a written request to the Custodian of Records at the Department of Economic Security, Division of Aging and Adult Services, Adult Protective Services, Central Office, 1789 W. Jefferson, Site code 950A, Phoenix, Arizona 85007. The request shall include the following information:
   1. The name, address, and telephone number of the person,
   2. The date and method of release, and
   3. A description of the information released.

D. If the request is on behalf of an organization or entity, the name and title of the person signing the request;

E. The purpose for which the information is sought;

F. The Section of A.R.S. § 41-1959(C) authorizing the person to obtain the information;

G. The name of the client who is the subject of the APS report, with as much of the following information as the requester can provide:
   a. Other possible spellings, names, or aliases of the client;
   b. The approximate date of the APS report; and,
   c. Any other data that the requester believes will be likely to assist the Department in identifying the information requested.

H. Upon receipt of a request for information, the Department shall determine if the request is complete. If the request is not complete, the Department shall contact the requester for the missing information.

I. The receipt date is the day that the receiving office designated on the request actually receives the complete request, as prescribed in subsection (B).

J. The Department shall respond to the requester within 15 business days.

K. The person releasing the information shall document the case record:
   1. The name of the person to whom the information was released,
   2. The date and method of release, and
   3. A description of the information released.

**R6-8-211. Repealed**

**Historical Note**
R6-8-211 recodified from A.A.C. R6-5-5611 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-212. Repealed**

**Historical Note**
R6-8-212 recodified from A.A.C. R6-5-5612 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-213. Repealed**

**Historical Note**
R6-8-213 recodified from A.A.C. R6-5-5613 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-214. Repealed**

**Historical Note**
R6-8-214 recodified from A.A.C. R6-5-5614 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-215. Repealed**

**Historical Note**
R6-8-215 recodified from A.A.C. R6-5-5615 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-216. Repealed**

**Historical Note**
R6-8-216 recodified from A.A.C. R6-5-5616 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-217. Repealed**

**Historical Note**
R6-8-217 recodified from A.A.C. R6-5-5617 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-218. Repealed**

**Historical Note**

**R6-8-219. Repealed**

**Historical Note**
R6-8-219 recodified from A.A.C. R6-5-5619 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-220. Repealed**

**Historical Note**
R6-8-220 recodified from A.A.C. R6-5-5620 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-221. Repealed**

**Historical Note**
R6-8-221 recodified from A.A.C. R6-5-5621 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-222. Repealed**

**Historical Note**
R6-8-222 recodified from A.A.C. R6-5-5622 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-223. Repealed**

**Historical Note**
R6-8-223 recodified from A.A.C. R6-5-5623 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).

**R6-8-224. Repealed**

**Historical Note**
R6-8-224 recodified from A.A.C. R6-5-5624 effective February 13, 1996 (Supp. 96-1). Repealed effective August 21, 1996 (Supp. 96-3).
41-1954. **Powers and duties**

A. In addition to the powers and duties of the agencies listed in section 41-1953, subsection E, the department shall:

1. Administer the following services:

   (a) Employment services, including manpower programs and work training, field operations, technical services, unemployment compensation, community work and training and other related functions in furtherance of programs under the social security act, as amended, the Wagner-Peyser act, as amended, the federal unemployment tax act, as amended, 33 United States Code, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

   (b) Individual and family services, which shall include a section on aging, services to children, youth and adults and other related functions in furtherance of social service programs under the social security act, as amended, title IV, except parts B and E, grants to states for aid and services to needy families with children and for child welfare services, title XX, grants to states for services, the older Americans act, as amended, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

   (c) Income maintenance services, including categorical assistance programs, special services unit, child support collection services, establishment of paternity services, maintenance and operation of a state case registry of child support orders, a state directory of new hires, a support payment clearinghouse and other related functions in furtherance of programs under the social security act, title IV, grants to states for aid and services to needy families with children and for child welfare services, title XX, grants to states for services, as amended, and other related federal acts and titles.

   (d) Rehabilitation services, including vocational rehabilitation services and sections for the blind and visually impaired, communication disorders, correctional rehabilitation and other related functions in furtherance of programs under the vocational rehabilitation act, as amended, the Randolph-Sheppard act, as amended, and other related federal acts and titles.

   (e) Administrative services, including the coordination of program evaluation and research, interagency program coordination and in-service training, planning, grants, development and management, information, legislative liaison, budget, licensing and other related functions.

   (f) Manpower planning, including a state manpower planning council for the purposes of the federal-state-local cooperative manpower planning system and other related functions in furtherance of programs under the comprehensive employment and training act of 1973, as amended, and other related federal acts and titles.

   (g) Economic opportunity services, including the furtherance of programs prescribed under the economic opportunity act of 1967, as amended, and other related federal acts and titles.

   (h) Intellectual disability and other developmental disability programs, with emphasis on referral and purchase of services. The program shall include educational, rehabilitation, treatment and training services and other related functions in furtherance of programs under the developmental disabilities services and facilities construction act (P.L. 91-517) and other related federal acts and titles.

   (i) Nonmedical home and community based services and functions, including department-designated case management, housekeeping services, chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite sitter care, attendant care, home delivered meals and other related services and functions.

2. Provide a coordinated system of initial intake, screening, evaluation and referral of persons served by the department.
3. Adopt rules it deems necessary or desirable to further the objectives and programs of the department.

4. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

5. Employ and determine the conditions of employment and prescribe the duties and powers of administrative, professional, technical, secretarial, clerical and other persons subject to chapter 4, article 4 and, as applicable, article 5 of this title as may be necessary in the performance of its duties, contract for the services of outside advisors, consultants and aides as may be reasonably necessary and reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business.

6. Make contracts and incur obligations within the general scope of its activities and operations subject to the availability of funds.

7. Contract with or assist other departments, agencies and institutions of the state, local and federal governments in the furtherance of its purposes, objectives and programs.

8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.

9. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

10. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of its duties subject to the departmental rules on the confidentiality of information.

11. Establish and maintain separate financial accounts as required by federal law or regulations.

12. Advise and make recommendations to the governor and the legislature on all matters concerning its objectives.

13. Have an official seal that is judicially noticed.

14. Annually estimate the current year's population of each county, city and town in this state, using the periodic census conducted by the United States department of commerce, or its successor agency, as the basis for such estimates and deliver such estimates to the economic estimates commission before December 15.

15. Estimate the population of any newly annexed areas of a political subdivision as of July 1 of the fiscal year in which the annexation occurs and deliver such estimates as promptly as is feasible after the annexation occurs to the economic estimates commission.

16. Establish and maintain a statewide program of services for persons who are both hearing impaired and visually impaired and coordinate appropriate services with other agencies and organizations to avoid duplication of these services and to increase efficiency. The department of economic security shall enter into agreements for the utilization of the personnel and facilities of the department of economic security, the department of health services and other appropriate agencies and organizations in providing these services.

17. Establish and charge fees for deposit in the department of economic security prelayoff assistance services fund to employers who voluntarily participate in the services of the department that provide job service and retraining for persons who have been or are about to be laid off from employment. The department shall charge only those fees necessary to cover the costs of administering the job service and retraining services.

18. Establish a focal point for addressing the issue of hunger in this state and provide coordination and assistance to public and private nonprofit organizations that aid hungry persons and families throughout this state. Specifically such activities shall include:
(a) Collecting and disseminating information regarding the location and availability of surplus food for
distribution to needy persons, the availability of surplus food for donation to charity food bank organizations,
and the needs of charity food bank organizations for surplus food.

(b) Coordinating the activities of federal, state, local and private nonprofit organizations that provide food
assistance to the hungry.

(c) Accepting and disbursing federal monies, and any state monies appropriated by the legislature, to private
nonprofit organizations in support of the collection, receipt, handling, storage and distribution of donated or
surplus food items.

(d) Providing technical assistance to private nonprofit organizations that provide or intend to provide services to
the hungry.

(e) Developing a state plan on hunger that, at a minimum, identifies the magnitude of the hunger problem in this
state, the characteristics of the population in need, the availability and location of charity food banks and the
potential sources of surplus food, assesses the effectiveness of the donated food collection and distribution
network and other efforts to alleviate the hunger problem, and recommends goals and strategies to improve the
status of the hungry. The state plan on hunger shall be incorporated into the department's state comprehensive
plan prepared pursuant to section 41-1956.

(f) Establishing a special purpose advisory council on hunger pursuant to section 41-1981.

19. Establish an office to address the issue of homelessness and to provide coordination and assistance to public
and private nonprofit organizations that prevent homelessness or aid homeless individuals and families
throughout this state. These activities shall include:

(a) Promoting and participating in planning for the prevention of homelessness and the development of services
to homeless persons.

(b) Identifying and developing strategies for resolving barriers in state agency service delivery systems that
inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of
being homeless.

(c) Assisting in the coordination of the activities of federal, state and local governments and the private sector
that prevent homelessness or provide assistance to homeless people.

(d) Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist
in alleviating homelessness.

(e) Serving as a clearinghouse on information regarding funding and services available to assist homeless
persons and persons in danger of being homeless.

(f) Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

(g) Submitting an annual report to the governor, the president of the senate and the speaker of the house of
representatives on the status of homelessness and efforts to prevent and alleviate homelessness. The department
shall provide a copy of this report to the secretary of state.

20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities
in this state to collect data and conduct projects in the United States and Mexico on issues that are within the
scope of the department's duties and that relate to quality of life, trade and economic development in this state in
a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of
this state and of the Arizona-Mexico region.
21. Exchange information, including case specific information, and cooperate with the department of child safety for the administration of the department of child safety's programs.

B. If the department of economic security has responsibility for the care, custody or control of a child or is paying the cost of care for a child, it may serve as representative payee to receive and administer social security and United States department of veterans affairs benefits and other benefits payable to such child. Notwithstanding any law to the contrary, the department of economic security:

1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies as it receives to be retained separate and apart from the state general fund on the books of the department of administration.

2. May use such monies to defray the cost of care and services expended by the department of economic security for the benefit, welfare and best interests of the child and invest any of the monies that the director determines are not necessary for immediate use.

3. Shall maintain separate records to account for the receipt, investment and disposition of funds received for each child.

4. On termination of the department of economic security's responsibility for the child, shall release any funds remaining to the child's credit in accordance with the requirements of the funding source or in the absence of such requirements shall release the remaining funds to:

(a) The child, if the child is at least eighteen years of age or is emancipated.

(b) The person responsible for the child if the child is a minor and not emancipated.

C. Subsection B of this section does not pertain to benefits payable to or for the benefit of a child receiving services under title 36.

D. Volunteers reimbursed for expenses pursuant to subsection A, paragraph 5 of this section are not eligible for workers' compensation under title 23, chapter 6.

E. In implementing the temporary assistance for needy families program pursuant to Public Law 104-193, the department shall provide for cash assistance to two-parent families if both parents are able to work only on documented participation by both parents in work activities described in title 46, chapter 2, article 5, except that payments may be made to families who do not meet the participation requirements if:

1. It is determined on an individual case basis that they have emergency needs.

2. The family is determined to be eligible for diversion from long-term cash assistance pursuant to title 46, chapter 2, article 5.

F. The department shall provide for cash assistance under temporary assistance for needy families pursuant to Public Law 104-193 to two-parent families for no longer than six months if both parents are able to work, except that additional assistance may be provided on an individual case basis to families with extraordinary circumstances. The department shall establish by rule the criteria to be used to determine eligibility for additional cash assistance.

G. The department shall adopt the following discount medical payment system for persons who the department determines are eligible and who are receiving rehabilitation services pursuant to subsection A, paragraph 1, subdivision (d) of this section:

1. For inpatient hospital admissions and outpatient hospital services the department shall reimburse a hospital according to the rates established by the Arizona health care cost containment system administration pursuant to section 36-2903.01, subsection G.
2. The department's liability for a hospital claim under this subsection is subject to availability of funds.

3. A hospital bill is considered received for purposes of paragraph 5 of this subsection on initial receipt of the legible, error-free claim form by the department if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

4. The department shall require that the hospital pursue other third-party payors before submitting a claim to the department. Payment received by a hospital from the department pursuant to this subsection is considered payment by the department of the department's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, if the department receives the claim directly from the hospital, the department shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the department shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the department shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the department shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K or any other established fee schedule the department determines reasonable.

H. The department shall not pay claims for services pursuant to this section that are submitted more than nine months after the date of service for which the payment is claimed.

I. To assist in the location of persons or assets for the purpose of establishing paternity, establishing, modifying or enforcing child support obligations and other related functions, the department has access, including automated access if the records are maintained in an automated database, to records of state and local government agencies, including:

1. Vital statistics, including records of marriage, birth and divorce.

2. State and local tax and revenue records, including information on residence address, employer, income and assets.
3. Records concerning real and titled personal property.

4. Records of occupational and professional licenses.

5. Records concerning the ownership and control of corporations, partnerships and other business entities.


7. Records of agencies administering public assistance programs.

8. Records of the motor vehicle division of the department of transportation.


10. Any system used by a state agency to locate a person for motor vehicle or law enforcement purposes, including access to information contained in the Arizona criminal justice information system.

J. Notwithstanding subsection I of this section, the department or its agents shall not seek or obtain information on the assets of an individual unless paternity is presumed pursuant to section 25-814 or established.

K. Access to records of the department of revenue pursuant to subsection I of this section shall be provided in accordance with section 42-2003.

L. The department also has access to certain records held by private entities with respect to child support obligors or obligees, or individuals against whom such an obligation is sought. The information shall be obtained as follows:

1. In response to a child support subpoena issued by the department pursuant to section 25-520, the names and addresses of these persons and the names and addresses of the employers of these persons, as appearing in customer records of public utilities, cable operators and video service providers.

2. Information on these persons held by financial institutions.

M. Pursuant to department rules, the department may compromise or settle any support debt owed to the department if the director or an authorized agent determines that it is in the best interest of this state and after considering each of the following factors:

1. The obligor's financial resources.

2. The cost of further enforcement action.

3. The likelihood of recovering the full amount of the debt.

N. Notwithstanding any law to the contrary, a state or local governmental agency or private entity is not subject to civil liability for the disclosure of information made in good faith to the department pursuant to this section.
41-1003. **Required rule making**

Each agency shall make rules of practice setting forth the nature and requirements of all formal procedures available to the public.
46-134. **Powers and duties; expenditure; limitation**

The state department shall:

1. Administer all forms of public relief and assistance except those that by law are administered by other departments, agencies or boards.

2. Develop a section of rehabilitation for the visually impaired that shall include a sight conservation section, a vocational rehabilitation section in accordance with the federal vocational rehabilitation act, a vending stand section in accordance with the federal Randolph-Sheppard act and an adjustment service section that shall include rehabilitation teaching and other social services deemed necessary, and shall cooperate with similar agencies already established. The administrative officer and staff of the section for the blind and visually impaired shall be employed only in the work of that section.

3. Assist other departments, agencies and institutions of the state and federal governments, when requested, by performing services in conformity with the purposes of this title.

4. Act as agent of the federal government in furtherance of any functions of the state department.

5. Carry on research and compile statistics relating to the entire public welfare program throughout this state, including all phases of dependency and defectiveness.

6. Cooperate with the superior court in cases of delinquency and related problems.

7. Develop plans in cooperation with other public and private agencies for the prevention and treatment of conditions giving rise to public welfare and social security problems.

8. Make necessary expenditures in connection with the duties specified in paragraphs 5, 6, 7, 13 and 14 of this subsection.

9. Have the power to apply for, accept, receive and expend public and private gifts or grants of money or property on the terms and conditions as may be imposed by the donor and for any purpose provided for by this chapter.

10. Make rules, and take action necessary or desirable to carry out the provisions of this title, that are not inconsistent with this title.

11. Administer any additional welfare functions required by law.

12. If a tribal government elects to operate a cash assistance program in compliance with the requirements of the United States department of health and human services, with the review of the joint legislative budget committee, provide matching monies at a rate that is consistent with the applicable fiscal year budget and that is not more than the state matching rate for the aid to families with dependent children program as it existed on July 1, 1994.

13. Furnish a federal, state or local law enforcement officer, at the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the recipient and notifies the agency that the recipient is a fugitive felon or a probation, parole or community supervision violator or has information that is necessary for the officer to conduct the official duties of the officer and the location or apprehension of the recipient is within these official duties.

14. In conjunction with Indian tribal governments, request a federal waiver from the United States department of agriculture that will allow tribal governments that perform eligibility determinations for temporary assistance for needy families programs to perform the food stamp eligibility determinations for persons who apply for services pursuant to section 36-2901, paragraph 6, subdivision (a). If the waiver is approved, the state shall provide the
state matching monies for the administrative costs associated with the food stamp eligibility based on federal guidelines. As part of the waiver, the department shall recoup from a tribal government all federal fiscal sanctions that result from inaccurate eligibility determinations.
46-182. Section powers and duties; costs

The section, in carrying out the provisions of the older Americans act of 1965, Public Law 89-73, as amended, shall:

1. Cooperate with the federal commissioner on aging and provide information to the administration on aging, department of health, education and welfare upon request.

2. Assist the department in preparing a state plan for the administration of the state program for the aging which shall set forth the provisions contained in section 303 of the older Americans act of 1965.

3. Serve as a clearing house for information related to state problems of the aged and aging. Gather and disseminate information and conduct hearings, conferences and special studies on problems and programs concerning the aging.

4. Develop plans, conduct and arrange for research and demonstration programs in the field of aging.

5. Provide consultation to counties and subdivisions thereof with respect to local community programs for the aged and aging. Develop, coordinate, and assist other public and private organizations which serve the aging.

6. Prepare, publish and disseminate educational materials dealing with the health and welfare of aged persons. Stimulate public awareness of the problems of the aging by conducting a program of public education and encourage the governor and the legislature to develop programs to deal with such problems.

7. Stimulate more effective use of existing resources and available services for the aged and aging, including coordination of the activities of other state departments, and the collaboration with such departments, agencies or commissions, with county officials and voluntary agencies and with state and local professional associations and societies for the aged and aging.
46-191. Definitions

In this article, unless the context otherwise requires:

1. "Adult day care" or "adult day health" means services which provide adults with optimal personal care in a group setting during a portion of a twenty-four hour day. This service provides planned care and supervision, recreation and socialization, personal care, personal living skills training, congregate meals and health monitoring and may include health related services such as preventive, therapeutic and restorative health care.

2. "Attendant care" means a service which provides a trained attendant to provide assistance with homemaking, general supervision and personal care.

3. "Case management services" means the assessment and development of an individualized service plan through which the eligibility of individuals is determined, appropriate services or benefits are identified, planned, reported, monitored or terminated and follow-up is provided if and when appropriate.

4. "Home care services" means services provided to an individual who is functionally impaired and unable to perform activities of daily living. These services include case management, assessment of functional impairment and needed community services, home care, housekeeping chore services, home health aid, personal care, visiting nurse services, adult day care, adult day health, respite care, attendant care and home delivered meals.

5. "Home delivered meals service" means a nutritious meal which contains at least one-third of the recommended dietary allowance for an individual and is delivered to the individual's place of residence.

6. "Home health aid" means services which provide intermittent health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living within the individual's place of residence.

7. "Nonmedical home and community based care system" means a comprehensive, case managed system of care which is provided to a functional person with a disability in the person's home or community and which supports the role of the family and caregivers as a part of the care plan which may include personal care, housekeeper chore services, adult day care, adult day health care, respite care and home delivered meals, as well as health care services which are a necessary, but subordinate, part of the care plan.

8. "Older Arizonan" means a resident of this state who is at least sixty years of age.

9. "Person with a physical disability" means an individual who has a physical impairment that substantially limits one or more major life activities and who has a diagnosis of such impairment.

10. "Personal care" means assistance to meet essential personal physical needs.

11. "Respite sitter services" means short-term care and supervision which may be required to be available on a twenty-four hour basis.

12. "Visiting nurse services" means services which provide intermittent skilled nursing services in the individual's place of residence. Skilled nursing services may include health maintenance, continued treatment or supervision of a health condition.
46-192. Identification of services

A. The department, in conjunction with other state and local government agencies and community organizations and agencies, shall identify those services provided by state departments and agencies that are appropriate services to implement the goal of enabling older Arizonans to maintain the most independence and freedom, avoid institutional care and live in dignity. In addition to existing services, such services may include the following:

1. General information services, including publication of available services, information and referral and outreach.

2. Transportation, including transportation necessary to guarantee access to services.

3. Nutrition, socialization and education.

4. Nonmedical home and community based care including case management, assessment of functional impairment and needed community services, home care, housekeeping chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite care, attendant care and home delivered meals.

5. Physical and mental health services, including inpatient and outpatient care, screening, appliances and supplies, mental health and home health care.

6. Placement services, including nursing homes, supervisory care, personal care, foster care and day care.

7. Protective advocacy and legal services.

8. Education, including senior adult education programs and training and research in the field of aging.

9. Volunteer and leadership development services.

10. Self-support services, including employment services, job development and income maintenance.

B. The department shall develop a basic plan to coordinate the services identified in this section and other appropriate services so as to avoid duplication and increase efficiency.

C. The department of health services, the department of transportation, the Arizona department of education and other appropriate state departments and agencies shall cooperate in coordinating services under the basic plan.

D. The department shall develop a comprehensive agreement by which the personnel and facilities of the department, the department of health services, the department of transportation, the Arizona department of education and other appropriate departments and agencies are utilized in carrying out this article provided that such agreement:

1. Results in more economical performance of duties of those departments and agencies.

2. Allows the department to contract for the services of consultants and agencies, subject to the availability of funding for such purpose.

E. The department may provide information and assist local agencies and organizations that provide services to older Arizonans.

F. The department may, under grant programs, utilize older Americans as staff to implement this article.

G. The integrity of senior citizen participation at all planning and program development levels shall be ensured.
H. The director shall designate an employee within the department to be responsible for the direction, planning, coordination and administration of the department's responsibilities under this article.
46-193. **Respite care for care givers of the elderly program; definition**

The department shall develop and implement a statewide program to provide respite care for care givers of the elderly. The department shall establish guidelines regarding the distribution of monies and respite care services. For the purposes of this section, "respite care" means short-term care and supervision services provided to an individual to relieve the care giver.
46-451. Definitions; program goals

A. In this chapter, unless the context otherwise requires:

1. "Abuse" means:

(a) Intentional infliction of physical harm.

(b) Injury caused by negligent acts or omissions.

(c) Unreasonable confinement.

(d) Sexual abuse or sexual assault.

2. "Adult protective services central intake unit" means a unit of specialized staff within adult protective services that is responsible for receiving reports of alleged abuse, neglect or exploitation of vulnerable adults or making the necessary resource referrals.

3. "De facto conservator" means any person who takes possession of the estate of a vulnerable adult, without right or lawful authority. A de facto conservator is subject to all of the responsibilities that attach to a legally appointed conservator or trustee.

4. "De facto guardian" means any person who takes possession of the person of a vulnerable adult, without right or lawful authority. A de facto guardian is subject to all of the responsibilities that attach to a legally appointed guardian.

5. "Exploitation" means the illegal or improper use of a vulnerable adult or the vulnerable adult's resources for another's profit or advantage.

6. "Health professional" has the same meaning prescribed in section 32-3201.

7. "Informed consent" means any of the following:

(a) A written expression by the person that the person fully understands the potential risks and benefits of the withdrawal of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health and that the person desires that the services be withdrawn. A written expression is valid only if the person is of sound mind and if the consent is witnessed by at least two individuals who do not benefit by the withdrawal of services.

(b) Consent to withdraw food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health as permitted by an order of a court of competent jurisdiction.

(c) A declaration made pursuant to title 36, chapter 32.

(d) Consent by another person under a durable power of attorney relating to health care services to withdraw food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health.

8. "Neglect" means the deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating or other services necessary to maintain a vulnerable adult's minimum physical or mental health.

9. "Protective services" means a program of identifiable and specialized social services that may offer social services appropriate to resolve problems of abuse, exploitation or neglect of a vulnerable adult.
10. "Protective services worker" means a person who has been selected by and trained under the requirements prescribed by the department to provide protective services.

11. "Vulnerable adult" means an individual who is eighteen years of age or older and who is unable to protect himself from abuse, neglect or exploitation by others because of a physical or mental impairment. Vulnerable adult includes an incapacitated person as defined in section 14-5101.

B. Protective services programs shall seek to maintain the adult in the adult's familiar environment by strengthening the adult's capacity for self-maintenance or by providing supportive services.

C. This section does not mean that an adult is abused, neglected or in need of protective services for the sole reason that the adult relies on treatment from a recognized religious method of healing in lieu of medical treatment.

D. For the purposes of this section, a person is not exploited by a transfer of assets if the transfer is to obtain or maintain eligibility for benefits under title 36, chapter 29 or benefits for supplemental security income, medicare or veterans' administration programs and the transfer of assets is between the person and any of the following:

1. The person's spouse.

2. The person's child with a disability.

3. A trust for the benefit of the person's spouse or child with a disability.

E. A transfer of assets for the purpose of obtaining or maintaining eligibility for benefits under title 36, chapter 29 shall comply with 42 United States Code section 1396p and sections 36-2934 and 36-2934.01.
A. A protective services worker shall:

1. Receive reports of abused, exploited or neglected vulnerable adults.

2. Receive from any source oral or written information regarding an adult who may be in need of protective services.

3. On receipt of such information make an evaluation to determine if the adult is in need of protective services and what services, if any, are needed.

4. Offer an adult in need of protective services or his guardian whatever services appear appropriate in view of the evaluation.

5. File petitions as necessary for the appointment of a guardian or conservator or the appointment of a temporary guardian or temporary conservator or make application for a special visitation warrant as provided for in title 14, chapter 5.

B. The department or a protective services worker employed by the department may not be appointed as guardian, conservator or temporary guardian.

C. An adult protective services worker is immune from civil liability for applying for a special visitation warrant or for filing a petition for guardianship or conservatorship unless the application or filing is done in bad faith.

D. For the purposes of this chapter, communications concerning a person who is incarcerated in any jail, prison, detention center or correctional facility or concerning a patient in the Arizona state hospital are not reports that require evaluation by a protective services worker.
46-452.01. Office of state long-term care ombudsman

The office of state long-term care ombudsman is established pursuant to the older Americans act of 1965, as amended (P.L. 100-175; United States Code section 307(a)(12)). The state long-term care ombudsman is under the direct supervision of the department of economic security, aging and adult administration program administrator or his designee. The department shall adopt rules for the purpose of implementing the state long-term care ombudsman program.
46-452.02. State long-term care ombudsman; duties; immunity from liability

A. A representative of the office of the state long-term care ombudsman who performs the official duties of the long-term care ombudsman is not liable under state law for the good faith performance of official duties.

B. Official duties of the office of the state long-term care ombudsman include authority to:

1. Enter long-term care facilities to communicate with residents.

2. Hear, investigate and attempt to resolve complaints by agreement, mediation or conciliation.

3. Render advice to residents of facilities.

4. Refer cases involving abuse, neglect, exploitation or health and safety to adult protective services or the appropriate licensing agency.

5. Make appropriate referrals to legal services or other community services.

6. Assume such other responsibilities as required pursuant to the older Americans act of 1965, as amended (P.L. 100-175; 42 United States Code section 3027(a)(12)).

C. Subject to available monies, the office of the state long-term care ombudsman shall visit each long-term care facility in this state without prior notice at least two times each calendar year to speak with residents of the long-term care facility, or the resident's representative if the resident is nonverbal, without the presence of the facility's staff. The requirements of this subsection are in addition to any follow-up in response to a complaint.

D. Official duties of the office of the state long-term care ombudsman do not include activities performed by a licensed health care provider as defined in section 12-561.
46-453. **Immunity of participants; nonprivileged communication**

A. Any person making a complaint, furnishing a report, information or records required or authorized by this chapter or otherwise participating in the program authorized by this chapter or in a judicial or administrative proceeding or investigation resulting from reports, information or records submitted or obtained pursuant to this chapter is immune from any civil or criminal liability by reason of such action, unless the person acted with malice or unless such person has been charged with or is suspected of abusing, exploiting or neglecting the vulnerable adult in question. Except as provided in subsection B of this section the physician-patient privilege, husband-wife privilege or any privilege except the attorney-client privilege, provided for by professions such as the practice of social work or nursing covered by law or a code of ethics regarding practitioner-client confidences, both as they relate to the competency of the witness and to the exclusion of confidential communications, shall not pertain in any civil or criminal litigation in which a vulnerable adult's exploitation, abuse or neglect is an issue nor in any judicial or administrative proceeding resulting from a report, information or records submitted or obtained pursuant to section 46-454 nor in any investigation of a vulnerable adult's exploitation, abuse or neglect conducted by a peace officer or a protective services worker.

B. In any civil or criminal litigation in which incapacitation, abuse, exploitation or neglect of a vulnerable adult is an issue, a clergyman or priest shall not, without his consent, be examined as a witness concerning any confession made to him in his role as a clergyman or a priest in the course of the discipline enjoined by the church to which he belongs.
46-454. Duty to report abuse, neglect and exploitation of vulnerable adults; duty to make medical records available; violation; classification

A. A health professional, emergency medical technician, home health provider, hospital intern or resident, speech, physical or occupational therapist, long-term care provider, social worker, peace officer, medical examiner, guardian, conservator, fire protection personnel, developmental disabilities provider, employee of the department of economic security or other person who has responsibility for the care of a vulnerable adult and who has a reasonable basis to believe that abuse, neglect or exploitation of the adult has occurred shall immediately report or cause reports to be made of such reasonable basis to a peace officer or to the adult protective services central intake unit. The guardian or conservator of a vulnerable adult shall immediately report or cause reports to be made of such reasonable basis to the superior court and the adult protective services central intake unit. All of the above reports shall be made immediately by telephone or online.

B. If an individual listed in subsection A of this section is an employee or agent of a health care institution as defined in section 36-401 and the health care institution's procedures require that all suspected abuse, neglect and exploitation be reported to adult protective services as required by law, the individual is deemed to have complied with the requirements of subsection A of this section by reporting or causing a report to be made to the health care institution in accordance with the health care institution's procedures.

C. An attorney, accountant, trustee, guardian, conservator or other person who has responsibility for preparing the tax records of a vulnerable adult or a person who has responsibility for any other action concerning the use or preservation of the vulnerable adult's property and who, in the course of fulfilling that responsibility, discovers a reasonable basis to believe that abuse, neglect or exploitation of the adult has occurred shall immediately report or cause reports to be made of such reasonable basis to a peace officer or to the adult protective services central intake unit. All of the above reports shall be made immediately by telephone or online.

D. Reports pursuant to subsections A and C of this section shall contain:

1. The names and addresses of the adult and any persons having control or custody of the adult, if known.
2. The adult's age and the nature and extent of the adult's vulnerability.
3. The nature and extent of the abuse, neglect or exploitation.
4. Any other information that the person reporting believes might be helpful in establishing the cause of the abuse, neglect or exploitation.

E. Any person other than one required to report or cause reports to be made in subsection A or C of this section who has a reasonable basis to believe that abuse, neglect or exploitation of a vulnerable adult has occurred may report the information to a peace officer or to the adult protective services central intake unit.

F. A person having custody or control of medical or financial records of a vulnerable adult for whom a report is required or authorized under this section shall make those records, or a copy of those records, available to a peace officer or adult protective services worker investigating the vulnerable adult's abuse, neglect or exploitation on written request for the records signed by the peace officer or adult protective services worker. Records disclosed pursuant to this subsection are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from a report required or authorized under this section.

G. If reports pursuant to this section are received by a peace officer, the peace officer shall notify the adult protective services central intake unit as soon as possible and make that information available to them.

H. A person required to receive reports pursuant to subsection A, C or E of this section may take or cause to be taken photographs of the abused adult and the vicinity involved. Medical examinations, including radiological examinations of the involved adult, may be performed. Accounts, inventories or audits of the exploited adult's
property may be performed. The person, department, agency or court that initiates the photographs, examinations, accounts, inventories or audits shall pay the associated costs in accordance with existing statutes and rules. If any person is found to be responsible for the abuse, neglect or exploitation of a vulnerable adult in a criminal or civil action, the court may order the person to make restitution as the court deems appropriate.

I. If psychiatric records are requested pursuant to subsection F of this section, the custodian of the records shall notify the attending psychiatrist, who may excise from the records, before they are made available:

1. Personal information about individuals other than the patient.

2. Information regarding specific diagnosis or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.

J. If any portion of a psychiatric record is excised pursuant to subsection I of this section, a court, on application of a peace officer or adult protective services worker, may order that the entire record or any portion of the record containing information relevant to the reported abuse, neglect or exploitation be made available to the peace officer or adult protective services worker investigating the abuse, neglect or exploitation.

K. A licensing agency shall not find that a reported incidence of abuse at a care facility by itself is sufficient grounds to allow the agency to close the facility or to find that all residents are in imminent danger.

L. Retaliation against a person who in good faith reports abuse, neglect or exploitation is prohibited. Retaliation against a vulnerable adult who is the subject of a report is prohibited. Any adverse action taken against a person who reports abuse, neglect or exploitation or a vulnerable adult who is the subject of the report within ninety days after the report is filed is presumed to be retaliation.

M. A person who violates this section is guilty of a class 1 misdemeanor, except if the failure to report involves an offense listed in title 13, chapter 14, the person is guilty of a class 6 felony.
46-455. Permitting life or health of a vulnerable adult to be endangered by neglect; violation; classification; civil remedy; definition

A. A person who has been employed to provide care, who is a de facto guardian or de facto conservator or who has been appointed by a court to provide care to a vulnerable adult and who causes or permits the life of the adult to be endangered or that person's health to be injured or endangered by neglect is guilty of a class 5 felony.

B. A vulnerable adult whose life or health is being or has been endangered or injured by neglect, abuse or exploitation may file an action in superior court against any person or enterprise that has been employed to provide care, that has assumed a legal duty to provide care or that has been appointed by a court to provide care to such vulnerable adult for having caused or permitted such conduct. A physician licensed pursuant to title 32, chapter 13 or 17, a podiatrist licensed pursuant to title 32, chapter 7, a registered nurse practitioner licensed pursuant to title 32, chapter 15 or a physician assistant licensed pursuant to title 32, chapter 25, while providing services within the scope of that person's licensure, is not subject to civil liability for damages under this section unless either:

1. At the time of the events giving rise to a cause of action under this section, the person was employed or retained by the facility or designated by the facility, with the consent of the person, to serve the function of medical director as that term is defined or used by federal or state law governing a nursing care institution, an assisted living center, an assisted living facility, an assisted living home, an adult day health care facility, a residential care institution, an adult care home, a skilled nursing facility or a nursing facility.

2. At the time of the events giving rise to a cause of action under this section, all of the following applied:

   (a) The person was a physician licensed pursuant to title 32, chapter 13 or 17, a podiatrist licensed pursuant to title 32, chapter 7, a registered nurse practitioner licensed pursuant to title 32, chapter 15 or a physician assistant licensed pursuant to title 32, chapter 25.

   (b) The person was the primary provider responsible for the medical services to the patient while the patient was at one of the facilities listed in paragraph 1 of this subsection.

C. Any person who was the primary provider of medical services to the patient in the last two years before it was recommended that the patient be admitted to one of the facilities listed in subsection B, paragraph 1 of this section is exempt from civil liability for damages under this section.

D. For the purposes of this section, primary provider does not include a consultant or specialist as listed in subsection B, paragraph 2, subdivision (a) of this section who is requested by the primary provider to provide care to the patient for whom the primary provider is responsible, unless that consultant or specialist assumes the primary care of the patient.

E. The state may file an action pursuant to this section on behalf of those persons endangered or injured to prevent, restrain or remedy the conduct described in this section.

F. The superior court has jurisdiction to prevent, restrain and remedy the conduct described in this section, after making provision for the rights of all innocent persons affected by such conduct and after a hearing or trial, as appropriate, by issuing appropriate orders.

G. Before a determination of liability, the orders may include, but are not limited to, entering restraining orders or temporary injunctions or taking such other actions, including the acceptance of satisfactory performance bonds, the creation of receiverships and the appointment of qualified receivers and the enforcement of constructive trusts, as the court deems proper.

H. After a determination of liability such orders may include, but are not limited to:

   1. Ordering any person to divest himself of any direct or indirect interest in any enterprise.
2. Imposing reasonable restrictions, including permanent injunctions, on the future activities or investments of any person including prohibiting any person from engaging in the same type of endeavor or conduct to the extent permitted by the constitutions of the United States and this state.

3. Ordering dissolution or reorganization of any enterprise.

4. Ordering the payment of actual and consequential damages, as well as costs of suit, to those persons injured by the conduct described in this section. The court or jury may order the payment of punitive damages under common law principles that are generally applicable to the award of punitive damages in other civil actions.

5. Ordering the payment of all costs and expenses of the prosecution and investigation of the conduct described in this section, civil and criminal, incurred by the state or county as appropriate to be paid to the general fund of this state or the county that incurred such costs and expenses.

I. A defendant convicted in any criminal proceeding is precluded from subsequently denying the essential allegations of the criminal offense of which he was convicted in any civil proceeding. For the purposes of this subsection, a conviction may result from a verdict or plea, including a plea of no contest.

J. A person who files an action under this section shall serve notice and one copy of the pleading on the attorney general within thirty days after the action is filed with the superior court. The notice shall identify the action, the person and the person's attorney. Service of the notice does not limit or otherwise affect the right of this state to maintain an action under this section or intervene in a pending action nor does it authorize the person to name this state or the attorney general as a party to the action. Upon receipt of a complaint the attorney general shall notify the appropriate licensing agency.

K. The initiation of civil proceedings pursuant to this section shall be commenced within two years after actual discovery of the cause of action.

L. Except for the standard of proof provided in subsection H, paragraph 4 of this section, the standard of proof in civil actions brought pursuant to this section is the preponderance of the evidence.

M. Except in cases filed by a county attorney, the attorney general, upon timely application, may intervene in any civil action or proceeding brought under this section if the attorney general certifies that in his opinion the action is of special public importance. Upon intervention, the attorney general may assert any available claim and is entitled to the same relief as if the attorney general had instituted a separate action.

N. In addition to the state's right to intervene as a party in any action under this section, the attorney general may appear as a friend of the court in any proceeding in which a claim under this section has been asserted or in which a court is interpreting section 46-453 or this section.

O. A civil action authorized by this section is remedial and not punitive and does not limit and is not limited by any other civil remedy or criminal action or any other provision of law. Civil remedies provided under this title are supplemental and not mutually exclusive.

P. The cause of action or the right to bring a cause of action pursuant to subsection B or E of this section shall not be limited or affected by the death of the vulnerable adult.

Q. For the purposes of this section, "enterprise" means any corporation, partnership, association, labor union or other legal entity, or any group of persons associated in fact although not a legal entity, that is involved with providing care to a vulnerable adult.
46-456. Duty to a vulnerable adult; financial exploitation; civil penalties; exceptions; definitions

A. A person who is in a position of trust and confidence to a vulnerable adult shall use the vulnerable adult's assets solely for the benefit of the vulnerable adult and not for the benefit of the person who is in the position of trust and confidence to the vulnerable adult or the person's relatives unless any of the following applies:

1. The superior court gives prior approval of the transaction on a finding that the transaction is for the benefit of the vulnerable adult.

2. The transaction is specifically authorized in a valid durable power of attorney that is executed by the vulnerable adult as the principal or in a valid trust instrument that is executed by the vulnerable adult as a settlor.

3. The transaction is required in order to obtain or maintain eligibility for services under title 36, chapter 29.

4. The person in the position of trust and confidence to the vulnerable adult is the vulnerable adult's spouse and the transaction furthers the interest of the marital community, including applying for benefits pursuant to title 36, chapter 29 or benefits for supplemental security income, medicare or veterans' administration programs.

B. A person who violates subsection A of this section or section 13-1802, subsection B shall be subject to actual damages and reasonable costs and attorney fees in a civil action brought by or on behalf of a vulnerable adult and the court may award additional damages in an amount up to two times the amount of the actual damages.

C. In addition to the damages prescribed in subsection B of this section, the court may:

1. Order a person who violates subsection A of this section or section 13-1802, subsection B to forfeit all or a portion of the person's:

   (a) Interest in any governing instrument.

   (b) Benefits under title 14, chapter 2 with respect to the estate of the vulnerable adult, including an intestate share, an elective share, an omitted spouse's share, an omitted child's share, a homestead allowance, any exempt property and a family allowance. If the vulnerable adult died intestate, the vulnerable adult's intestate estate passes as if the person who violated subsection A of this section or section 13-1802, subsection B disclaimed that person's intestate share to the extent the court orders that person to forfeit all or a portion of the person's benefits under title 14, chapter 2.

2. Revoke, in whole or in part, any revocable:

   (a) Disposition or appointment of property that is made in a governing instrument by the vulnerable adult to the person who violates subsection A of this section or section 13-1802, subsection B.

   (b) Provision by the vulnerable adult that is contained in a governing instrument that confers a general or nongeneral power of appointment on the person who violates subsection A of this section or section 13-1802, subsection B.

   (c) Nomination or appointment by the vulnerable adult that is contained in a governing instrument that nominates or appoints the person who violates subsection A of this section or section 13-1802, subsection B to serve in any fiduciary or representative capacity, including serving as a personal representative, executor, guardian, conservator, trustee or agent.

3. Sever the interests of the vulnerable adult and the person who violates subsection A of this section or section 13-1802, subsection B in any property that is held by them at the time of the violation as joint tenants with the right of survivorship or as community property with the right of survivorship, and transform the interests of the vulnerable adult and the person who violated subsection A of this section or section 13-1802, subsection B into tenancies in common. To the extent that the person who violated subsection A of this section or section 13-
1802, subsection B did not provide adequate consideration for the jointly held interest, the court may cause the person's interest in the subject property to be forfeited in whole or in part.

D. A revocation or a severance under subsection C, paragraph 2 or 3 of this section does not affect any third party interest in property that was acquired for value and in good faith reliance on apparent title by survivorship in the person who violated subsection A of this section or section 13-1802, subsection B unless a writing declaring the severance has been noted, registered, filed or recorded in records that are appropriate to the kind and location of the property and that are relied on as evidence of ownership in the ordinary course of transactions involving that property.

E. If the court imposes a revocation under subsection C, paragraph 2 of this section, provisions of the governing instrument shall be given effect as if the person who violated subsection A of this section or section 13-1802, subsection B disclaimed all provisions revoked by the court or, in the case of a revocation of a nomination in a fiduciary or representative capacity, the person who violated subsection A of this section or section 13-1802, subsection B predeceased the decedent.

F. Section 46-455, subsections F, G, H, I, K, L, M and P also apply to civil violations of this section.

G. The vulnerable adult or the duly appointed conservator or personal representative of the vulnerable adult's estate has priority to, and may file, a civil action under this section. If an action is not filed by the vulnerable adult or the duly appointed conservator or personal representative of the vulnerable adult's estate, any other interested person, as defined in section 14-1201, may petition the court for leave to file an action on behalf of the vulnerable adult or the vulnerable adult's estate. Notice of the hearing on the petition shall comply with section 14-1401.

H. Subsections A, B, C, D, E and F of this section do not apply to an agent who is acting within the scope of the person's duties as, or on behalf of, any of the following:

1. A bank, financial institution or escrow agent licensed or certified pursuant to title 6.
2. A securities dealer or salesman registered pursuant to title 44, chapter 12, article 9.
3. An insurer, including a title insurer, authorized and regulated pursuant to title 20.
4. A health care institution licensed pursuant to title 36, chapter 4 that provides services to the vulnerable adult.

I. A civil action brought by a person in a position of trust and confidence against a vulnerable adult regarding a governing instrument established by the vulnerable adult is presumed not to be for the benefit of the vulnerable adult unless it is shown otherwise by clear and convincing evidence.

J. For the purposes of this section:

1. "Asset" includes all forms of personal and real property.
2. "Disposition or appointment of property" includes a transfer of an item of property or any other benefit of a beneficiary designated in a governing instrument.
3. "For the benefit of the vulnerable adult" includes any act that is consistent with the clearly stated wishes of the vulnerable adult found by the court to be made without coercion and while the vulnerable adult was of sound mind.
4. "Governing instrument" means a deed, a will, a trust, a custodianship, an insurance or annuity policy, an account with pay on death designation, a security registered in beneficiary form, a pension, a profit sharing, retirement or similar benefit plan, a family limited partnership, an instrument creating or exercising a power of appointment, a power of attorney, an estate planning document or a dispositive, appointive or nominative instrument of any similar type.
5. "Position of trust and confidence" means that a person is any of the following:

(a) A person who has assumed a duty to provide care to the vulnerable adult.

(b) A joint tenant or a tenant in common with a vulnerable adult.

(c) A person who is in a fiduciary relationship with a vulnerable adult including a de facto guardian or de facto conservator.

(d) A person who is in a confidential relationship with the vulnerable adult. The issue of whether a confidential relationship exists shall be an issue of fact to be decided by the court based on the totality of the circumstances.

(e) A beneficiary of the vulnerable adult in a governing instrument.

6. "Revocable" means a disposition, appointment, provision or nomination under which the vulnerable adult, at the time of or immediately before death, was alone empowered, by law or under the governing instrument, to cancel the designation in favor of the person who violated subsection A of this section or section 13-1802, subsection B, whether or not the vulnerable adult was then empowered to designate the vulnerable adult in place of the person who violated subsection A of this section or section 13-1802, subsection B or the vulnerable adult then had capacity to exercise the power.
46-457. Elder abuse central registry; mandatory reporting; release of information

A. A person who files an action under this article shall serve notice and one copy of the pleading with the attorney general within thirty days after the action is filed in the superior court. The notice shall identify the action, the person against whom the civil complaint has been filed and that person's attorney. The person who files an action is responsible for submitting a report on the final disposition of the case within thirty days after the final action is taken.

B. Except as otherwise provided in this subsection, a state agency other than adult protective services that renders an administrative decision that substantiates the allegation of abuse or that files a civil action that alleges abuse, neglect or financial exploitation pursuant to this article or title 36 shall serve notice and one copy of the administrative decision or pleading with the attorney general within thirty days after the administrative decision is rendered or within thirty days after the action is filed in the superior court. The agency is responsible for submitting a report on the final disposition of the case within thirty days after the final action is taken. Adult protective services shall report its findings to the registry established pursuant to section 46-459. The department of economic security shall not provide the notice prescribed in this subsection for information maintained in the adult protective services registry pursuant to section 46-459.

C. If the victim of the offense is a vulnerable adult, a person who files a criminal complaint or indictment involving a violation of this article or section 13-1102, 13-1103, 13-1104, 13-1105, 13-1201, 13-1203, 13-1204, 13-1303, 13-1304, 13-1403, 13-1404, 13-1406, 13-1802, 13-1807, 13-2002, 13-2310 or 13-3623 shall submit a copy of the criminal complaint or indictment to the attorney general within thirty days after arraignment. Within thirty days of the date of issuance of the minute entry the court shall endorse to the attorney general a copy of the sentencing minute entry or the minute entry reflecting the case has been dismissed or a judgment of acquittal has been entered. The attorney general shall develop guidelines to implement this subsection.

D. The attorney general shall maintain a registry containing the names of persons pursuant to subsection A, B or C of this section with the date the action was filed with the superior court or the date the administrative decision was rendered, the dates of the conduct set forth in the complaint, the indictment or decision, the general nature of the complaint, indictment or decision and the disposition of the complaint, indictment or decision, if known.

E. The information maintained pursuant to subsection D of this section is available to the public on written request to the custodian of the registry.

F. A person may submit a written statement on that person's own behalf to the custodian of the registry. The statement is part of the records for distribution in response to all inquiries concerning that person.

G. A person or agency that distributes information in the registry in good faith is not subject to civil or criminal liability.
46-458. Hearing process; definitions

A. After completing its investigation, the department shall notify a person who is alleged to have abused, neglected or exploited a vulnerable adult that the department intends to enter a substantiated finding of abuse, neglect or exploitation in the registry and of that person's right:

1. To receive a copy of the report containing the allegation and findings.

2. To a hearing before entry into the registry pursuant to section 46-459.

B. The department shall send the notice prescribed in subsection A of this section by first class mail not more than fifteen calendar days after completion of the investigation.

C. A request for a hearing on the proposed finding must be received by the department within fifteen calendar days of the notice date.

D. If a request for a hearing is made pursuant to subsection C of this section, the department shall notify the reporting source, the vulnerable adult and the vulnerable adult's representative of record and conduct a review before the hearing. The department shall provide an opportunity for the accused person to provide written or verbal information to support the position that the department should not substantiate the allegation and an opportunity for the reporting source, the vulnerable adult and the vulnerable adult’s representative of record to respond to the information provided by the accused person. If the department determines that the accused person did not engage in the alleged conduct by a preponderance of the evidence, the department shall amend the information or finding in the report and shall notify the person, and a hearing shall not be held.

E. Notwithstanding section 41-1061, subsection B, the notification prescribed in subsection A of this section shall also state that if the department does not amend the information or finding in the report as prescribed in subsection D of this section within sixty days after it receives the request for a hearing the person has a right to a hearing unless either:

1. The person is a party in a civil, criminal or administrative proceeding in which the allegations of abuse, neglect or exploitation are at issue.

2. A court or administrative law judge has made findings as to the alleged abuse, neglect or exploitation.

F. If the department does not amend the information or finding in the report as prescribed in subsection D of this section, the department shall notify the office of administrative hearings of the request for a hearing not later than five days after completion of the review. The department shall forward all records, reports and other relevant information with the request for hearing within ten days after the request is made. The department shall redact the identity of the reporting source before transmitting the information to the office of administrative hearings.

G. The office of administrative hearings shall hold a hearing pursuant to title 41, chapter 6, article 10, with the following exceptions:

1. A vulnerable adult who is the victim of or a witness to abuse, neglect or exploitation is not required to testify at the hearing.

2. The identity of the reporting source of the abuse, neglect or exploitation shall not be disclosed without the permission of the reporting source.

3. The reporting source is not required to testify.

4. A written statement from the reporting source may be admitted if the time, content and circumstances of that statement are sufficiently indicative of its reliability.
5. If the person requesting the hearing fails to appear, the hearing shall be vacated and a substantiated finding of abuse, neglect or exploitation shall be entered. On good cause shown, the hearing may be rescheduled if the request is made within fifteen calendar days after the date of the notice vacating the hearing for failure to appear.

H. On completion of the presentation of evidence, the administrative law judge shall determine whether the department's finding that the accused engaged in the alleged conduct is supported by a preponderance of the evidence. If the administrative law judge determines there is insufficient evidence to sustain the department's burden of proof, the administrative law judge shall order the department to amend the information or finding in the report.

I. Notwithstanding section 41-1959, the department shall notify the person who is the subject of the investigation and the person who reported the allegations of abuse, neglect or exploitation of the outcome of the investigation at one of the following times:

1. At the conclusion of the investigation if the report is unsubstantiated or if, by a preponderance of the evidence, there is reason to believe the allegation did occur but no perpetrator has been identified.

2. After the time to request a hearing has lapsed pursuant to subsection C of this section without the department receiving a request for a hearing.

3. After a final administrative decision has been made.

J. All final decisions substantiating an allegation of abuse, neglect or exploitation shall be reported to the adult protective services registry, pursuant to section 46-459, within thirty days after the decision is rendered.

K. Any person receiving information pursuant to this section shall maintain its confidentiality as provided by section 41-1959, subsection A.

L. This section applies only to those allegations of abuse, neglect or exploitation received by the department on or after July 1, 2007.

M. The department is exempt from the rule making requirements of title 41, chapter 6 for the purposes of implementing this section.

N. For the purposes of this section:

1. "Amend the finding" means to change the finding from substantiated to unsubstantiated.

2. "Amend the information" means to change information identifying the accused of having abused, neglected or exploited a vulnerable adult.

3. "Final decision" means a decision for which the time to appeal has expired or from which no further appeal is available.
46-459. Adult protective services registry

A. The department of economic security shall maintain a registry of substantiated reports of abuse, neglect and exploitation of vulnerable adults made pursuant to section 46-458. The department shall incorporate duplicate reports on the same incident in the original report and shall not classify duplicate reports as new reports.

B. The registry shall contain the name and date of birth of the person determined to have abused, neglected or exploited a vulnerable adult, the nature of the allegation made and the date and description of the disposition of the allegation. The names of the vulnerable adult and reporting source shall not be reported to the registry.

C. The department shall maintain a report in the registry for twenty-five years after the date of entry.

D. The department shall annually purge reports and investigative outcomes received pursuant to the time frames prescribed in subsection C of this section.

E. Any person who was the subject of an adult protective services investigation may request confirmation that the department has purged information about the person pursuant to subsection D of this section. On receipt of this request, the department shall provide the person with written confirmation that the department has no record containing identifying information about that person.

F. Information maintained pursuant to subsection B of this section shall be made available to the public on written request and online. The department may charge a fee for processing written requests.

G. The department shall conduct an adult protective services registry background check for any person who is employed or seeking employment in a position that provides direct services to children or vulnerable adults in any of the following:

1. A community residential setting as defined in section 36-551.

2. An intermediate care facility for individuals with intellectual disabilities as defined in section 36-551.

3. Home and community based services pursuant to title 36, chapter 29, article 2.

4. Day care for persons who have developmental disabilities pursuant to title 36, chapter 29, article 2.

H. The department may conduct an adult protective services registry background check for any person who is employed or seeking employment with the department or one of the department's contractors in a position that provides direct services to children or vulnerable adults.

I. The department shall use the information contained in the adult protective services registry to determine the following:

1. Whether the person is qualified for home and community based services certification for services provided to vulnerable adults or children.

2. Whether the person who is employed or seeking employment with the department of economic security is qualified for a position that provides direct services to vulnerable adults or children.

3. Qualifications for positions that provide direct services to vulnerable adults or children for any of the following:

   (a) A person who applies for a contract with the department and that person's employees.

   (b) All employees of a contractor.

   (c) A subcontractor of a contractor and the subcontractor's employees.
(d) Prospective employees of a contractor or subcontractor at the request of the prospective employer.

J. Before being employed in a position that provides direct services to vulnerable adults or children, prospective employees shall certify under penalty of perjury on a form prescribed by the department whether an allegation of vulnerable adult abuse, neglect or exploitation has been made against the person and was substantiated.
46-460. Adult protective services information; confidentiality; allowed disclosures; violation; classification

A. Unless otherwise provided by law, all personally identifying information concerning any person who is involved in an adult protective services program, including the reporting source's identity, other than a perpetrator against whom an allegation of abuse, neglect or exploitation has been substantiated pursuant to section 46-458, and all information that is gathered or created by adult protective services and that is contained in adult protective services records is confidential and may not be released except as provided in subsections B, C and D of this section.

B. Employees of the department of economic security, the department of law and the court may obtain the information described in subsection A of this section in the performance of their duties as authorized by rules adopted by the director of the department to economic security.

C. Employees of the department of economic security may release any information that is otherwise held confidential under this section, including the identity of the person who makes a report of suspected abuse, neglect or exploitation, to the following or under any of the following circumstances:

1. Pursuant to a superior court order.

2. To law enforcement to be used only for purposes of conducting investigations.

3. To agencies that are responsible for investigating a report of abuse, neglect or exploitation when the investigation is authorized by statute or by an agreement with the department.

4. In any judicial or administrative proceeding involving an adult protective services client if the director considers the information pertinent to the proceeding.

5. To agencies of the federal government, any state, any political subdivision of any state for official purposes or any tribal government. All information received by a governmental agency pursuant to this paragraph shall be maintained as confidential, except where pertinent to a criminal prosecution.

D. Employees of the department of economic security may release any information that is otherwise held confidential under this section, except the reporting source's identity, to the following or under any of the following circumstances:

1. The client when a request is made in writing specifically requesting information that directly relates to the person requesting the information.

2. When necessary for purposes that are directly connected with the administration of adult protective services, including:

   (a) To protect against a clear and substantial risk of imminent serious injury to a client or to others.

   (b) In oral and written communications with the minimal necessary release of information needed to conduct an investigation of allegations of abuse, neglect or exploitation.

   (c) In oral and written communications to arrange specific services for a vulnerable adult.

   (d) To a person that has the legal responsibility or authorization to care for, evaluate, treat or supervise a vulnerable adult.

   (e) To the extent necessary to make claims on behalf of a client for public or private assistance, insurance or health or medical assistance pursuant to title 11, chapter 2, article 7 or title 36, chapter 29 to which the client may be entitled.
3. Pursuant to the consent of the client who is receiving adult protective services.

4. Persons identified by the client pursuant to one of the following:

   (a) If the client is present or otherwise available and has the capacity to make decisions, an adult protective services worker may disclose the information if one of the following applies:

      (i) The client agrees orally or in writing by signing a consent form that authorizes disclosure.

      (ii) The client is given an opportunity to object and does not express an objection.

   (b) If the client is not present or the opportunity to agree or object to the disclosure of information cannot practicably be provided because of the client's incapacity or an emergency circumstance, the adult protective services worker may disclose the information if the disclosure of the information is in the best interests of the client.

5. Any statutorily created team that is mandated to review adult protective services and the clients served in the completion of the official duties.

6. To disclose statistics or other summary information if personally identifiable information is not revealed by the disclosure.

7. To confirm, clarify, correct or supplement information concerning an allegation or actual instance of vulnerable adult abuse, neglect or exploitation that has been made public by a source or sources outside the department.

8. Any person who is engaged in bona fide research, if no personally identifying information is made available, unless it is essential to the research and the director or the director's designee gives prior approval. If the researcher wants to contact a subject of a record, the subject's consent must be obtained by the department before the contact.

E. The department may adopt rules to implement the purposes of the department and the duties and powers of the director under this chapter.

F. A person who violates this section is guilty of a class 2 misdemeanor.
46-461. Multidisciplinary adult protection team; duties; confidentiality; definition

A. Adult protective services may establish a multidisciplinary adult protection team consisting of employees of the adult protective services program, the county attorney or the county attorney's designees and representatives of law enforcement, behavioral health, domestic violence and sexual assault or other appropriate human service agencies. Representatives from local tribal governments and adult disability and advocate groups may be added to the multidisciplinary adult protection team.

B. The multidisciplinary adult protection team may provide public and professional education and develop resources for prevention, intervention and treatment to better enable the department to carry out its adult protection functions and to meet the community's needs for adult protection services.

C. Adult protective services may make available to members of the multidisciplinary adult protection team all information or records that are necessary for the official duties without the designation of the client's name unless the client's name is required for the official purposes. The case information received by members of the multidisciplinary adult protection team shall be maintained as confidential unless a consent to release has been given pursuant to this section or pursuant to a court order in this state or another state. Any member of the multidisciplinary adult protection team may share information that is acquired in the team member's professional capacity with other members of the multidisciplinary adult protection team to assist the multidisciplinary adult protection team in its function.

D. Case consultation may be performed by a committee of the team consisting of the team members representing social services, law enforcement, the county attorney, health care and persons directly involved in an individual case as determined by the case consultation committee.

E. A person to whom information is released pursuant to this section is prohibited from using or releasing the information except in the proper performance of the person's official duties unless a consent to release has been given pursuant to this section or pursuant to a court order or a grand jury subpoena.

F. For the purposes of this section, "case consultation" means a case review process that results in recommendations about services to be provided to an identified adult and family.
46-471. Definitions

In this article, unless the context otherwise requires:

1. "Broker-dealer" has the same meaning as dealer prescribed in section 44-1801.

2. "Eligible adult" means either of the following:
   (a) A person who is sixty-five years of age or older.
   (b) A person who is a vulnerable adult.

3. "Financial exploitation" means either of the following:
   (a) The wrongful or unauthorized taking, withholding, appropriating or use of money, assets or property of an eligible adult.
   (b) Any act or omission taken by a person, including through the use of a power of attorney, guardianship or conservatorship of an eligible adult, to either:
      (i) Obtain control through deception, intimidation or undue influence over the eligible adult's money, assets or property to deprive the eligible adult of the ownership, use, benefit or possession of the eligible adult's money, assets or property.
      (ii) Convert money, assets or property of the eligible adult to deprive the eligible adult of the ownership, use, benefit or possession of the eligible adult's money, assets or property.

4. "Investment adviser" means a person who is licensed or exempt from licensure as an investment advisor pursuant to title 44, chapter 13.

5. "Investment adviser representative" means a person who is licensed or exempt from licensure as an investment advisor representative pursuant to title 44, chapter 13.

6. "Qualified individual" means a broker-dealer, investment adviser or person who serves in a supervisory, compliance, legal or senior investor protection capacity for a broker-dealer or investment adviser.
46-472. Disclosures; immunity; third-party disclosures

A. Notwithstanding section 46-454, if a qualified individual reasonably believes that financial exploitation of an eligible adult may have occurred, may have been attempted or is being attempted, the qualified individual may notify adult protective services and the corporation commission.

B. A qualified individual who in good faith and exercising reasonable care makes a disclosure of information pursuant to subsection A of this section is immune from administrative or civil liability that might otherwise arise from the disclosure or for any failure to notify the customer of the disclosure.

C. If a qualified individual reasonably believes that financial exploitation of an eligible adult may have occurred, may have been attempted or is being attempted, a qualified individual may notify any third party previously designated by or reasonably associated with the eligible adult. A qualified individual may not notify any designated third party that is suspected of financial exploitation or other abuse of the eligible adult.

D. A qualified individual who in good faith and exercising reasonable care makes a disclosure pursuant to subsection C of this section is immune from any administrative or civil liability that might otherwise arise from the disclosure.
46-473. Delaying disbursements or transactions; immunity

A. A broker-dealer or investment adviser may delay a disbursement or transaction from an account of an eligible adult or an account on which an eligible adult is a beneficiary if both:

1. The broker-dealer, investment adviser or qualified individual reasonably believes, after initiating an internal review of the requested disbursement or transaction and the suspected financial exploitation, that the requested disbursement or transaction may result in financial exploitation of an eligible adult.

2. The broker-dealer or investment adviser does all of the following:

   (a) Immediately, but not more than two business days after the delayed disbursement or transaction, provides written notification of the delay and the reason for the delay to all parties authorized to transact business on the account, unless any party is reasonably believed to have engaged in suspected or attempted financial exploitation of the eligible adult.

   (b) Immediately, but not more than two business days after the delayed disbursement or transaction, notifies adult protective services and the corporation commission.

   (c) Continues its internal review of the suspected or attempted financial exploitation of the eligible adult, as necessary, and reports the investigation's results to adult protective services and the corporation commission on request.

B. A delayed disbursement or transaction expires on the earlier of:

1. A determination by the broker-dealer or investment adviser that the disbursement or transaction will not result in financial exploitation of the eligible adult.

2. Fifteen business days after the date on which the broker-dealer or investment adviser first delayed disbursement or transaction of the monies, unless either adult protective services or the corporation commission requests that the broker-dealer or investment adviser extend the delay, in which case the delay shall expire not more than twenty-five business days after the date on which the broker-dealer or investment adviser first delayed disbursement or transaction of the monies unless otherwise terminated or further extended by either adult protective services or the corporation commission or an order of a court of competent jurisdiction.

C. A court of competent jurisdiction may enter an order extending the delay of the disbursement or transaction of monies or may order other protective relief based on the petition of the corporation commission, adult protective services, the broker-dealer or the investment adviser that initiated the delay or another interested party.

D. A broker-dealer or investment adviser who in good faith and exercising reasonable care delays a disbursement or transaction is immune from administrative or civil liability that might otherwise arise from a delay in a disbursement or transaction in accordance with this section.
A. A broker-dealer or investment adviser shall provide access to or copies of records that are relevant to the suspected or attempted financial exploitation of an eligible adult to adult protective services and law enforcement, either as part of a referral to adult protective services or law enforcement, or on request of adult protective services or law enforcement pursuant to an investigation. The records may include historical records and records relating to the most recent transaction or transactions that may comprise financial exploitation of an eligible adult. All records made available to adult protective services or law enforcement under this section are not public records and are not subject to title 39, chapter 1, article 2.

B. This section does not limit or otherwise impede the authority of the corporation commission to access or examine the books and records of broker-dealers and investment advisers as otherwise provided by law.
BOARD OF TAX APPEALS
Title 16, Chapter 3, Article 1
Summary

This Five-Year Review Report (5YRR) from the Board of Tax Appeals (Board) relates to rules in Title 16, Chapter 3, Article 1 regarding Tax Appeal Procedures. These rules relate to general administration of income, transaction privilege, use, luxury, and all other types of taxation, other than property tax.

There was no Proposed Course of Action in the Board’s last 5YRR.

Proposed Action

The Board is not proposing any course of action for these rules.

1. **Has the agency analyzed whether the rules are authorized by statute?**

   Yes, the Board cites both general and specific statutory authority for the rules.
2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**

   The Board indicates that parties that appear before the Board consist of taxpayers, which may include small businesses, corporations, municipalities, as well as individuals, and the Arizona Department of Revenue as represented by an Assistant Attorney General. The Board had 144 appeals before it during the fiscal year. They state this number could increase significantly during the next fiscal year due to the anticipated number of appeals associated with the alternative fuel program. The Board indicates that after thoroughly reviewing its rules, the economic impact is unchanged in the review period.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   The Board states that it is a quasi-judicial administrative agency created to provide taxpayers with an independent, less formal, cost effective, expert review of decisions issued by the Department of Revenue, municipalities when appropriate, and now the Office of Administrative Hearings.

   Accordingly, the Board states it has always been a serious consideration and goal of the Board that the benefits of the Board’s rules outweigh the probable costs of the rules and impose the least burden and costs to persons regulated by the rules.

   The Board indicates there are no filing fees to appeal to the Board, and most taxpayers do not have to hire an attorney – unless required by state law, as in the case of certain corporations. The Board states, while its rules require parties to submit an original and six (6) copies of memoranda, taxpayers need only complete and submit an original and copies of the single, “fill-in” Notice of Appeal form provided by the Board to perfect their appeal and no memoranda are required from either party. The Board states the relatively minimal costs of the copies required by the Board, allows the Board to quickly disseminate information to the three (3) Board members, who review materials at home prior to hearing/meeting days when they come into the Board’s office, as well as the Board’s staff. Further the Board states a taxpayer can choose to submit an appeal on the records, or waive the hearing, negating the need to travel to the Board’s office if taxpayers choose not to or cannot travel. The Board indicates that its cost-benefit analysis of its rules confirms that the benefits of the Board’s rules outweigh the probable costs of the rules and imposes the least burden and cost to persons regulated by the rules.

4. **Has the agency received any written criticisms of the rules over the last five years?**

   No, the Board indicates they have not received any written criticisms of the rules over the last five years.

5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**

   Yes, the Board indicates the rules are clear, concise, and understandable.
6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**
   
   Yes, the Board indicates the rules are consistent with other rules and statutes.

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**
   
   Yes, the Board indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**
   
   Yes, the Board indicates the rules are enforced as written.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**
   
   Not applicable. The Board indicates there are no corresponding federal laws.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

    Not applicable. The Board indicates that the rules do not require a permit or license.

11. **Conclusion**

    This 5YRR from the Board of Tax Appeals relates to rules in Title 16, Chapter 3, Article 1 regarding Tax Appeal Procedures. The Board indicates the rules are clear, concise, understandable, consistent, effective, and enforced as written. The Board is not proposing any changes to these rules.

    Council staff finds the Department submitted a report that meets the requirements of A.R.S. § 41-1056. Council staff recommends approval of this report.
August 18, 2022

VIA EMAIL: grcc@azdoa.gov
Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, AZ 85007

RE: Arizona Board of Tax Appeals, A.R.S. §41-1056, Five Year Review Report - Revised

Dear Nicole Sornsin:

Please find enclosed the Five Year Review Report of The Arizona Board of Tax Appeals pursuant to A.R.S. §41-1056, which is due on June 28, 2022.

The report consists of:

1) Summary of the Five Year Review
2) Review Report of Each Rule
3) Cost/Benefit Analysis
4) Attachment A – Agency Rules
5) Attachment B – Authorizing Statutes
6) Attachment C – Economic, Small Business and Consumer Impact Statement

The Arizona Board of Tax Appeals hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact David V. Medina at 602.364.1102 or David.Medina@bota.az.gov.

Sincerely,

David V. Medina, Executive Director
SUMMARY OF FIVE YEAR REVIEW

Pursuant to A.R.S. § 41-1056, the Arizona Board of Tax Appeals ("Board") submits this five-year review. The review covers the rules in Title 16, Chapter Three of the Arizona Administrative Code which pertains to the general administration of income, transaction privilege, use, luxury, and all other types of taxation, other than property tax.

The Board reviewed each of its rules and finds that they are all currently enforced as written; they are all necessary, effective in achieving their objectives, consistent with state and federal statutes, clear, concise, understandable; and, require no revisions or amendments at this time.

There has been no known written criticisms regarding the Board’s rules in the last five years.

- Economic Impact

The economic impact to small business and consumers under the Board’s current rules should generally be the same as when the rules were promulgated. (See attachment C)
TITLE 16

CHAPTER THREE

ARTICLE 1. TAX APPEAL PROCEDURES

After thoroughly reviewing its rules, the Board finds that the analysis for the following categories apply to all of the Board's rules.

AUTHORIZATION

A.R.S. § 41-1003 provides that each agency shall make rules of practice setting forth the nature and requirements of all formal procedures available to the public. The Board derives its general rule-making authority from A.R.S. §§ 42-1252 and 1253 and hears appeals from orders or decisions of the municipal tax code commission under A.R.S. § 42-6003(G). See attachment "A."

CONSISTENCY AND ENFORCEMENT OF THE RULE

This rule is necessary to accomplish the objective of the Board. It is not inconsistent with any state or federal statutes or other rules of the agency and is currently being enforced without problem.

CLARITY, CONCISENESS AND UNDERSTANDABILITY

This rule is sufficiently clear, concise and understandable.

WRITTEN CRITICISM

The agency has not received written criticism of the statute within the last five years.

ECONOMIC IMPACT

Unchanged.

COMPETITIVE IMPACT ANALYSIS

No analysis comparing this rule's impact on the state's business competitiveness to the impact on businesses in other states has been submitted to the Board.

BURDEN AND COST

The Board has determined that the rule imposes negligible burden and cost to those participating in the appeals process and its probable benefits outweigh its probable cost.

STRINGENCY

The rule is not more stringent than corresponding federal or state law.

PROPOSED COURSE OF ACTION

No action is proposed for this rule.
OBJECTIVE / EFFECTIVENESS

R16-3-101. Definitions

The objective of this rule is to establish the definitions for specific terms used throughout the Board's rules. The rule effectively satisfies this objective.

R16-3-102. Notice of Appeal

The objective of this rule is to specify the information and documentation that must be filed with a notice of appeal and when a notice of appeal must be filed. The rule effectively satisfies this objective.

R16-3-103. Incomplete Notice of Appeal

The objective of this rule is to explain the circumstances under which an incomplete notice of appeal may be supplemented with additional required material and the consequences of failing to comply with the provisions of the rule. The rule effectively satisfies this objective.

R16-3-104. Memoranda, Waivers, and Supporting Authorities

The objective of this rule is to apprise parties of the requirements, including deadline schedules, for filing supporting memoranda, waivers and supporting authorities. The rule effectively satisfies this objective.

R16-3-105. Stipulation or Statements of Fact

The objective of this rule is to inform the parties that the Board may request parties to file a joint stipulation or separate statements of fact. The rule effectively satisfies this objective.

R16-3-106. Dismissal, Withdrawal, or Suspension of Appeal

The objective of this rule is to explain the conditions under which an appeal may be dismissed, withdrawn or suspended. The rule effectively satisfies this objective.

R16-3-107. Request for Hearing

The objective of this rule is to explain under what conditions an oral hearing will be set and when, the notice the parties will receive, and the conditions under which a hearing may be waived, postponed, continued or cancelled. The rule effectively satisfies this objective.

R16-3-108. Hearing Procedure

The objective of this rule is to inform the parties of the specific procedures to be followed in a hearing before the Board. The rule effectively satisfies this objective.
R16-3-109. Evidence Produced at the Hearing

The objective of this rule is to explain the procedures for introducing oral and documentary evidence. The rule effectively satisfies this objective.

R16-3-110. Official Notice

The objective of this rule is to identify the kind of information and documentation of which the Board will take official notice. The rule effectively satisfies this objective.

R16-3-111. Subpoena

The objective of this rule is to explain the items for which a subpoena may be issued and who will bear the cost. The rule effectively satisfies this objective.

R16-3-113. Transcripts and Records

The objective of this rule is to explain under what conditions a hearing will be transcribed and who will bear the cost and how file information may be obtained. The rule effectively satisfies this objective.

R16-3-114. Decision or Order

The objective of this rule is to generally describe the Board's decisions and orders and the procedures regarding them. The rule effectively satisfies this objective.

R16-3-115. Rehearing or Review of Decision or Order

The objective of this rule is to advise parties of the procedure for requesting a rehearing or review of a decision. The rule effectively satisfies this objective.
Cost/Benefit Analysis

The Board is a quasi-judicial administrative agency created to provide taxpayers with an independent, less formal, cost effective, expert review of decisions issued by the Department of Revenue, municipalities when appropriate and now the Office of Administrative Hearings.

Accordingly, it has always been a serious consideration and goal of the Board that the benefits of the Board's rules outweigh the probable costs of the rules and imposes the least burden and cost to persons regulated by the rules.

There are no filing fees to appeal to the Board, and most taxpayers do not have to hire an attorney -- unless required by state law, as in the case of certain corporations. While the Board's rules require taxpayers to submit an original plus 6 copies of their Notice of Appeal and both parties to submit an original and 6 copies of memoranda, taxpayers need only complete and submit an original and copies of the single, "fill-in" Notice of Appeal form provided by the Board to perfect their appeal and no memoranda are required from either party. The relatively minimal cost of the copies required by the Board, allows the Board to quickly disseminate information to the 3 Board members, who review materials at home prior to hearing/meeting days when they come into the Board's office, as well as the Board's staff. Further, a taxpayer can choose to submit an appeal on the record, or waive the hearing, negating the need to travel to the Board's office if taxpayers choose not to or cannot travel. The Board's cost/benefit analysis of its rules confirms that the benefits of the board's rules outweigh the probable costs of the rules and imposes the least burden and cost to persons regulated by the rules.
Arizona Board of Tax Appeals

Five-Year Review Report Attachment C – Economic Impact Statement
ECONOMIC, SMALL BUSINESS AND CONSUMER IMPACT STATEMENT

ARTICLE 1. TAX APPEAL PROCEDURES

R16-3-101. Definitions
R16-3-102. Notice of Appeal
R16-3-103. Incomplete Notice of Appeal
R16-3-104. Memoranda, Waivers, and Supporting Authorities
R16-3-105. Stipulation or Statement of Facts
R16-3-106. Dismissal, Withdrawal, or Suspension of Appeal
R16-3-107. Request for Hearing
R16-3-108. Hearing Procedure
R16-3-109. Evidence Produced at the Hearing
R16-3-110. Official Notice
R16-3-111. Subpoena
R16-3-113. Transcripts and Records
R16-3-114. Decision or Order
R16-3-115. Rehearing or Review of Decision or Order

Information Contained in this Report

This report contains information required by A.R.S. § 41-1055, which requires a cost and benefit analysis of the implementation of the proposed rules on the Arizona State Tax Appeals Board, political subdivisions, businesses, private and public employment, consumers and the public, and State revenues.
Costs and Benefits of Implementing R16-3-101 – R16-3-115

The parties that appear before the Board consist of taxpayers, which may include small businesses, corporations, municipalities, as well as individuals, and the Arizona Department of Revenue as represented by an Assistant Attorney General. The Board had 144 appeals before it during the last fiscal year. This number could increase significantly during the next fiscal year due to the anticipated number of appeals associated with the alternative fuel program. The implementation of the proposed rules will only minimally impact most participants in the tax appeals process and should result in no appreciable difference in the State’s revenue.

Current rules require parties to submit an original and one copy. The new rules require parties to submit six copies. Any minimal costs borne by parties appearing before the Board will be outweighed by the benefit of having copies immediately available for review by the parties, as well as the Clerk, Board members, and Hearing Officers who administer the appeals process. New page limitations in the proposed rules may further minimize the cost of the additional copies.

Although most memoranda filed with the Board already fall within the proposed page limitations, the page limits may result in an increased cost to parties due to the additional editing that may be required. New time limitations that reduce the number of days the parties have to file memoranda may result in additional cost to the parties because the memoranda must be prepared more quickly. The new time limitations may reduce the costs to parties, however, because appeals will be resolved more quickly, potentially reducing any accruing interest.

A.R.S. § 41-1035 describes the following methods for reducing the impact of new rules on small businesses:

1. Establish less stringent compliance or reporting requirements in the rule for small businesses.
2. Establish less stringent schedules or deadlines in the rule for compliance or reporting requirements for small businesses.

3. Consolidate or simplify the rule’s compliance or reporting requirements for small businesses.

4. Establish performance standards for small businesses to replace design or operational standards in the rule.

5. Exempt small businesses from any or all requirements of the rule.

The Board has considered these methods, as required by statute. However the Board is not a regulatory agency; therefore, the methods described are generally inapplicable. The Board’s rules are designed to simplify and expedite the tax appeals process for all taxpayers. Accordingly, there is no need to establish a different procedure for small businesses.
ARTICLE 1. TAX APPEAL PROCEDURES

R16-3-101. Definitions
For purposes of this Article:
1. “Appellant,” unless otherwise noted, means a taxpayer or the representative of a taxpayer, or other person or entity directly interested who is legally entitled to initiate proceedings before the Board.
2. “Board” means the State Board of Tax Appeals.
3. “Clerk” means the Clerk appointed by the Board to carry out the duties established by A.R.S. § 42-1252.
5. “Day” means a calendar day. If the last day for filing a document under the provisions of this Article falls on a Saturday, Sunday, or legal holiday, the document is considered timely if filed on the following business day.
6. “Department” means the Arizona Department of Revenue.
7. “Hearing Officer” means a person appointed by the Board to take oral testimony and other evidence, make recommendations, and carry out the duties of the Board established by A.R.S. § 42-1252.
8. “Memorandum” means a document that supports a party’s position.
9. “Notice of appeal” means a written request for correction or re determination, including all applicable attachments.
10. “Notice of determination” means a written notification of a final decision or order issued by the Department or any other governmental entity from which an appeal to the Board may be taken.

R16-3-102. Notice of Appeal
A. The Appellant shall sign the notice of appeal and mail or deliver the original and six copies to the Board’s office in Phoenix, Arizona. The Board shall consider a notice of appeal received by mail filed on the date shown by its postmark. In the absence of a legitimate postmark, the Board shall determine whether an appeal was timely filed.
B. The Appellant shall legibly type, write, or print the notice of appeal and include the following information:
1. The Appellant’s name, address, and telephone number. If there is a difference between the name on the notice of determination and the name on the notice of appeal, the notice of appeal shall contain an explanation of the difference;
2. The amount of money involved in the Department’s determination, the type of tax, the year or other period for which the determination was made, and, if different from the determination, the approximate amount of money at issue in the appeal;
3. A statement of issues involved in the appeal;
4. A statement of errors the Appellant alleges the Department committed in the determination;
5. The relief sought; and
6. Whether a hearing is requested. The Appellant may waive a previously requested hearing within 10 days after the due date of the reply memorandum.
C. The Appellant shall file six copies of the notice of determination and any findings of fact or conclusions of law issued by the Department or the OAH with the notice of appeal.
D. The Appellant shall file the notice of appeal not more than 30 days after the final decision or order of the Department or the OAH becomes final.
E. In addition to the requirements in subsections (A) through (D), a notice of appeal regarding reimbursement for fees or other costs shall include six copies of the following:
1. The application that was submitted to the Department for reimbursement of fees or other costs.
2. Documentation of payment of fees or other costs.
F. If the notice of appeal is filed by a person aggrieved by an order or decision of the Municipal Tax Code Commission, the Appellant shall file a signed notice of appeal within 30 days after receiving the Commission’s notice of the order or decision. The notice of appeal shall include the following information:
1. The name and address of each municipality;
2. The Appellant’s name, address, and telephone number;
3. The applicable tax rate of each municipality;
4. A statement of issues involved in the appeal;

March 31, 2002
5. The relief sought; and
6. Whether a hearing is requested.

G. The Appellant shall submit six copies of any municipal ordinance involved in the appeal.

**Historical Note**

**R16-3-103. Incomplete Notice of Appeal**

A. If the Appellant files a timely notice of appeal that is incomplete, the Clerk shall grant the Appellant 15 days to perfect the appeal.
B. Upon written request, the Clerk shall grant the Appellant a reasonable extension of time to comply with the provisions of this Section for good cause shown.
C. The Board may dismiss an appeal or exclude supplemental information for the Appellant’s failure to act in a timely manner.

**Historical Note**
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-103 renumbered and amended as Section R16-3-111, former Section R16-3-105 renumbered and amended as Section R16-3-103 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

**R16-3-104. Memoranda, Waivers, and Supporting Authorities**

A. Each party shall file an original and six copies of any memorandum filed with the Board. The Board shall provide a copy to the opposing party.
B. A party may waive in writing the right to file a memorandum any time before the memorandum is due.
C. The Appellant shall file a memorandum of not more than 15 pages that addresses the facts and law in support of the appeal within 20 days after filing the notice of appeal.
D. The Department shall file a response memorandum of not more than 15 pages within 20 days after receiving the Appellant’s memorandum or waiver.
E. The Appellant may file a reply memorandum of not more than 10 pages within 15 days after receiving the Department’s memorandum. The Appellant’s reply memorandum shall only address the issues of law or fact raised in the Department’s memorandum.
F. Each party shall file six copies of cited supporting authorities at the time the party files a memorandum.
G. Upon written request, the Board may grant a reasonable extension of time for filing a memorandum upon good cause shown.

**Historical Note**
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-104 renumbered and amended as Section R16-3-112, former Sections R16-3-106 and R16-3-107 renumbered and amended as Section R16-3-104 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

**R16-3-105. Stipulation or Statements of Fact**

At the Board’s request, the parties shall file a stipulation or separate statements of fact with any supporting affidavits or exhibits, listing the facts upon which they agree, the facts that are in dispute, and the reasons for the dispute. If there are no facts in dispute, this should be stated in the stipulation or statements.

**Historical Note**
Adopted effective December 30, 1974 (Supp. 75-1). Former Section R16-2-105 repealed, new Section R16-3-105 adopted effective January 7, 1977 (Supp. 77-1). Former Section R16-3-105 renumbered and amended as Section R16-3-103, former Section R16-3-108 renumbered and amended as Section R16-3-105 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

**R16-3-106. Dismissal, Withdrawal, or Suspension of Appeal**

A. If the Board lacks jurisdiction regarding an appeal, the Board shall dismiss the appeal on its own motion or on motion by the Department.
B. The Appellant may withdraw an appeal upon written notification to the Board or by the parties’ written stipulation at any time before the Board issues its decision.
C. The Board may suspend proceedings for a reasonable period of time at the written request of either party, the written stipulation of the parties, or its own discretion.

**Historical Note**
Adopted effective December 30, 1974 (Supp. 75-1). Former Section R16-3-106 repealed, new Section R16-3-106 adopted effective January 7, 1977 (Supp. 77-1). Former Section R16-3-106 renumbered and amended as Section R16-3-104, former Section R16-3-109 renumbered and amended as Section R16-3-106 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

**R16-3-107. Request for Hearing**

A. The Board shall schedule a hearing at the written request of either party. Either party may waive appearance, in writing, at least 10 days before the hearing.
B. A hearing officer or one or more members of the Board shall hold the hearing, taking testimony and other evidence.
C. The Board shall send a written notice to the parties of the date, time, and location of the hearing at least 20 days before the hearing. The Board shall ordinarily schedule one hour hearings. Upon written request, and after consideration of the hearing schedule, the Board may grant a party additional time for the hearing if the request is filed with the Clerk within 10 days after the due date of the reply memorandum.
D. The Board may postpone, continue, or cancel a hearing for good cause upon the written request of either party if the request is submitted at least 10 days before the hearing.
E. If a hearing is not requested, the Board shall consider the appeal submitted for decision based on the record.

**Historical Note**
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-107 renumbered and amended as Section R16-3-104, former Section R16-3-110 renumbered and amended as Section R16-3-107 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

**R16-3-108. Hearing Procedure**

A. A hearing shall ordinarily proceed in the following manner:
1. The Appellant may make an opening statement.
2. The Department may make an opening statement or reserve its opening statement until the close of the Appellant’s case.
3. The Appellant shall state its position and present its arguments and evidence.
4. The Department may make a previously-reserved opening statement, state its position, and present its arguments and evidence.
5. The Appellant may make a closing statement, presenting final arguments.
6. The Department may make a closing statement, presenting final arguments.
7. The Appellant may reply to the Department’s closing statement or final arguments.

B. The Board may direct a party to submit an additional memorandum or information within a reasonable period of time. The Board shall grant the opposing party a reasonable period of time to respond to the additional memorandum or information.

C. The Board may recess or continue a hearing for good cause.

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1).
Former Section R16-3-108 repealed, new Section R16-3-108 adopted effective January 7, 1977 (Supp. 77-1).
Former Section R16-3-108 renumbered and amended as Section R16-3-105, former Section R16-3-124 renumbered and amended as Section R16-3-108 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-109. Evidence Produced at the Hearing

A. The Board shall accept oral evidence only upon oath or affirmation.
B. Each party may call and examine witnesses, introduce exhibits, and cross-examine witnesses on any matter relevant to the appeal. The presiding officer at the hearing may call a party, or any other person who is present, to testify under oath or affirmation. The presiding officer and any member of the Board or its staff may question witnesses.
C. The Board may admit any relevant evidence, including affidavits and forms of hearsay evidence. The Board shall be liberal in admitting evidence but shall consider objections to the admission and comments on the weakness of evidence in assigning weight to the evidence.
D. The Board may admit carbon copies, photocopies, or copies made by similar procedures in place of original documents upon a showing of authenticity and proper foundation.
E. A party may substitute an exact legible copy for an exhibit upon written request if the request is submitted to the Board within 10 days after the hearing.

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-109 renumbered and amended as Section R16-3-106, former Section R16-3-114 renumbered and amended as Section R16-3-109 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-110. Official Notice

A. The Board may take official notice of the following without the production of additional evidence:
1. Records maintained by the Board.
2. Tax returns filed with the Department for or on behalf of the Appellant or any affiliated company and related records on file with the Department.
3. Any fact that may be judicially noticed by the courts of this state.

B. The parties may, refuse any matters officially noticed at any time before the Board’s decision or order becomes final.

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1).
Former Section R16-3-110 repealed, new Section R16-3-110 adopted effective January 7, 1977 (Supp. 77-1). Former Section R16-3-110 renumbered and amended as Section R16-3-107, former Section R16-3-115 renumbered and amended as Section R16-3-110 effective August 27, 1980 (Supp. 80-4). Former Section R16-3-110 repealed; new Section R16-3-110 renumbered from R16-3-116 and amended by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-111. Subpoena

The Board may, at its discretion or upon written request submitted by a party at least 15 days before a hearing, issue subpoenas for the attendance of witnesses or the production of books, records, documents, or other evidence that is not confidential or privileged. A subpoena shall be served on behalf of and at the expense of the party requesting its issuance.

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-111 renumbered and amended as Section R16-3-114, former Section R16-3-103 renumbered and amended as Section R16-3-111 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-112. Repealed

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-112 repealed, former Section R16-3-104 renumbered and amended as Section R16-3-112 effective August 27, 1980 (Supp. 80-4). Section repealed by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-113. Transcripts and Records

A. The hearing before the Board shall be transcribed upon written request submitted by a party to the Board at least five days before the hearing. The transcript shall be prepared at the expense of the requesting party.
B. A person shall not remove the records of the Board from its office for use as evidence or for other purposes. The Board shall provide certified copies of records as required under A.R.S. Title 39, Chapter 1.

**Historical Note**

Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-113 amended and former Section R16-3-123 renumbered and amended as Section R16-3-113 effective August 27, 1980 (Supp. 80-4). Section repealed; new Section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).
R16-3-114. Decision or Order
A. If a quorum of the Board agrees on a decision or order, the Board shall issue the decision or order.
B. The Board shall issue all decisions or orders in writing and shall include separately-stated findings of fact and conclusions of law.
C. The Board shall mail, return receipt requested, or hand deliver a decision or order to the parties.
D. Except in the case of a tax dispute between municipalities, a decision or order is final 30 days after the Appellant receives it unless an aggrieved party files a motion for rehearing or review within 15 days after receipt.
E. In a dispute between municipalities, a decision or order is final on the date of receipt by the party. An aggrieved party has 30 days to appeal the decision or order of dismissal to the tax court.

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-114 renumbered and amended as Section R16-3-109. Former Section R16-3-111 renumbered and amended as Section R16-3-114 effective August 27, 1980 (Supp. 80-4). Section repealed; new section made by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-115. Rehearing or Review of Decision or Order
A. The Board may grant a rehearing or review of a decision or order based on a motion by an aggrieved party, or at its own discretion, for any of the following reasons:
1. The findings of fact, conclusions of law, order, or decision are not supported by the evidence or are contrary to law.
2. The party seeking review was deprived of a fair hearing due to irregularity in the proceedings, abuse of discretion, or misconduct of the prevailing party.
3. Accident or surprise which could not have been prevented by ordinary prudence.
4. Material evidence, newly discovered, which with reasonable diligence could not have been discovered and produced at the hearing.
5. Error in admission or rejection of evidence, or other errors of law occurring at the hearing or during the progress of the action.
6. The decision is the result of passion, bias or prejudice.
B. Enforcement of a decision of the Board is stayed pending a determination on the motion for rehearing or review. If a motion for rehearing or review is denied, the stay is automatically lifted. The decision becomes final 30 days after the Appellant is notified of the Board’s action on the motion for rehearing or review.
C. The aggrieved party shall ensure that the motion for a rehearing or review is in writing and specifies the grounds upon which the motion is based. The aggrieved party may amend the motion at any time before the Board rules on it.
D. If the Board desires a response to the motion for rehearing or review from the opposing party, the Board shall notify the opposing party in writing and allow a reasonable period of time for preparation and filing of the response.
E. After granting a motion for rehearing or review, the Board may take additional testimony, amend findings of fact or conclusions of law, or make new findings or conclusions, and issue a new decision, depending on the particular circumstances of the appeal.

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-115 renumbered and amended as Section R16-3-110. Former Sections R16-3-116 and R16-3-117 renumbered and amended as Section R16-3-115 effective August 27, 1980 (Supp. 80-4). Former Section R16-3-115 repealed; new Section R16-3-115 renumbered from R16-3-121 and amended by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-116. Reversed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-116 renumbered and amended as Section R16-3-115, former Section R16-3-118 renumbered and amended as Section R16-3-116 effective August 27, 1980 (Supp. 80-4). Section R16-3-116 renumbered to R16-3-110 by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-117. Repealed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Former Section R16-3-117 renumbered and amended as Section R16-3-115, former Section R16-3-118 renumbered and amended as Section R16-3-116 effective August 27, 1980 (Supp. 80-4). Section repealed by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-118. Repealed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-118 renumbered and amended as Section R16-3-116, former Section R16-3-120 renumbered and amended as Section R16-3-118 effective August 27, 1980 (Supp. 80-4). Section repealed by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-119. Repealed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-119 renumbered and amended as Section R16-3-117, former Sections R16-3-121 and R16-3-122 renumbered and amended as Section R16-3-119 effective August 27, 1980 (Supp. 80-4). Section repealed by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-120. Repealed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1). Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-120 renumbered and amended as Section R16-3-118, former Section R16-3-125 renumbered and amended as Section R16-3-120 effective August 27, 1980 (Supp. 80-4). Section repealed by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-121. Repealed

Historical Note
Adopted effective December 30, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1). Former Section R16-3-121 renumbered and amended as Section R16-3-119, former Section R16-3-126 renumbered and amended as Section R16-3-121 effective August 27, 1980 (Supp. 80-4). Section renumbered to R16-3-115 by final rulemaking at 8 A.A.R. 836, effective February 7, 2002 (Supp. 02-1).

R16-3-122. Renumbered

Historical Note
Adopted effective December 24, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1).
Renumbered and amended as Section R16-3-119 effective August 27, 1980 (Supp. 80-4).

R16-3-123. Renumbered

Historical Note
Adopted effective December 24, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1).
Renumbered and amended as Section R16-3-113 effective August 27, 1980 (Supp. 80-4).

R16-3-124. Renumbered

Historical Note
Adopted effective December 24, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1).
Renumbered and amended as Section R16-3-108 effective August 27, 1980 (Supp. 80-4).

R16-3-125. Renumbered

Historical Note
Adopted effective December 24, 1974 (Supp. 75-1).
Amended effective January 7, 1977 (Supp. 77-1).
Renumbered and amended as Section R16-3-120 effective August 27, 1980 (Supp. 80-4).

R16-3-126. Renumbered

Historical Note
Adopted effective January 7, 1977 (Supp. 77-1). Renumbered and amended as Section R16-3-121 effective August 27, 1980 (Supp. 80-4).
42-1252. State board of tax appeals

A. The state board of tax appeals is established as an independent agency which shall not in any way be subject to the supervision or control of the department of revenue. The board shall have full power to hear and decide all appeals from decisions of the department of revenue.

B. The state board shall consist of three members appointed by the governor pursuant to section 38-211. Members shall be residents of this state.

C. Members shall be selected on the basis of their knowledge of and experience in taxation. Not more than two members may be primarily engaged in the same occupation or profession. The board shall handle all matters entrusted by law to it dealing with income taxation, estate taxation, transaction privilege, use and luxury taxation and any other taxation assigned to it by law and shall hear and decide appeals from the department of revenue on such matters.

D. Not more than two members of the board shall be members of the same political party. No member of the board shall hold any other public office under the laws of this state or any of its political subdivisions. No member shall be a candidate for an elective office under the laws of this state, nor of any other state. No member of the board shall hold any position of trust nor provide or engage in any occupation or business which would corruptly conflict with the duties of a member of the board, nor take part directly or indirectly in any election campaign in the interest of any political party or other organization or any candidate or measure to be voted on by the people. This subsection does not prohibit a person from properly and lawfully engaging in a business or profession.

E. The term of board members is six years. The member of the board having the shortest term remaining shall act as chairperson if that member has served on the board at least two years. If the member having the shortest term remaining does not qualify to act as chairperson or if two or more members have an equal right by virtue of their remaining terms to serve as chairperson, the board shall elect a chairperson. A member may not be appointed for more than two terms.

F. Each member of the board shall receive:

1. One hundred fifty dollars per day for time spent in the performance of official duties.

2. Such travel and other expenses as provided by law for other state officers.

G. The governor may remove any member for cause.

H. Subject to title 41, chapter 4, article 4, the board shall appoint a clerk, hearing officers and such other employees as it deems necessary to carry out its duties. The hearing officer qualifications shall be the same as the selection criteria for the members as prescribed by this section. Notwithstanding section 41-192, subsection D, upon request of the board, the attorney general shall designate, for such time and purposes as the board requires, an attorney, acceptable to the board, whose compensation shall be fixed and paid by the board.

I. The board shall hold hearings and meetings at the call of the chairperson or a majority of the board and otherwise as may be prescribed by the rules of the board as required to carry out its duties. The principal office of the board shall be at the capitol, but the board may sit or hold hearings at any other place within the state. A majority of the board constitutes a quorum for making orders and decisions or transacting other official business, and the board may act even though one position on the board is vacant. The board shall keep a record of its proceedings.

J. In conducting the business of the board:

1. The board may not act if more than one position is vacant.
2. One or more members or a hearing officer of the board may hold hearings and take testimony to be reported for action by the board when authorized by rule or order of the board.
42-1253. Appeal to state board of tax appeals; definition

A. Except as provided in section 42-1254, subsection C, a person aggrieved by a final decision or order of the department under section 42-1251, article 3 of this chapter or section 42-2065, 42-2068, 42-2069, 42-2074, 42-2201 or 42-2202 may appeal to the state board of tax appeals by filing a notice of appeal in writing within thirty days after the decision or order from which the appeal is taken has become final.

B. The board shall take testimony and examine documentary evidence as necessary to determine the appeal, all pursuant to administrative rules to govern such appeals.

C. On determining the appeal the board shall issue a decision consistent with its determination. The board’s decision is final on the expiration of thirty days from the date when notice of its action is received by the taxpayer, unless either the department or the taxpayer brings an action in tax court as provided in section 42-1254.

D. If the amount in any single dispute before the board is less than twenty-five thousand dollars, a taxpayer may be represented in that dispute before the board by:

1. A certified public accountant.

2. A person who is enrolled to practice before the United States internal revenue service and is recognized as an enrolled agent.

3. Any other person who is authorized by the taxpayer under a properly executed power of attorney and who was previously or is currently retained by the taxpayer for purposes other than representation in a hearing before the board.

E. If a practitioner who represents a taxpayer before the board pursuant to subsection D of this section fails to comply with an order or rule of the board, the board may impose sanctions including one or both of the following:

1. Order that the stipulation of the facts proposed by the department of revenue be accepted.

2. Suspend the practitioner from further practice before the board either for a specific period of time or until the board removes the suspension.

F. For the purposes of this section, "practitioner" means a person, other than a party, who files documents with or appears before the board in connection with a matter before the board.
42-6003. Multi-municipal taxes: determination of municipality entitled to levy and collect taxes; appeal; definitions

A. Except as otherwise provided in this section, a taxpayer who has paid transaction privilege taxes on a transaction to an appropriate city or town, or qualified for an exemption from transaction privilege taxes under the ordinance of an appropriate city or town, is not required to pay transaction privilege taxes on the same transaction to any other city or town.

B. If a city or town asserts, in whole or in part, the right to a tax which was paid to an appropriate city or town, the cities and towns claiming the tax shall attempt to resolve allocation of the tax among themselves. Except as otherwise provided in this section, the taxpayer shall not be a party to the dispute but may be compelled to give evidence or produce books and records.

C. If a city or town asserts the right to tax a transaction which is exempt from transaction privilege taxes under the ordinance of an appropriate city or town, the city or town asserting the right to tax and the city or town which the taxpayer asserts is an appropriate city or town shall attempt to resolve which city or town has the superior jurisdictional claim. Except as otherwise provided in this section, the taxpayer shall not be a party to the dispute but may be compelled to give evidence or produce books and records.

D. If the cities or towns involved cannot resolve the dispute arising under subsection B or C, any city or town which is a party to the dispute may submit the issue to the municipal tax code commission for resolution. The taxpayer may intervene in any proceeding before the commission to assist in resolving the dispute. The commission shall determine which city or town has the superior jurisdictional claim, based upon its respective ordinances and common law principles related to transaction privilege taxation, and, if the taxpayer paid tax on the transaction, shall award the entire tax to the prevailing city or town.

E. If it is determined that the taxpayer should have paid taxes to a city or town with a higher tax rate than the city or town to which the tax was actually paid, the taxpayer is liable for the tax at the higher rate only on transactions occurring after the taxable month of the written notification requirement provided in subsection H.

F. If a city or town with a higher tax rate asserts a claim to transaction privilege taxes paid to an appropriate city or town with a lower tax rate, the taxpayer may submit the issue to the municipal tax code commission for resolution and may intervene as a party in a proceeding before the commission to resolve the dispute.

G. Any party aggrieved by an order or decision of the municipal tax code commission may appeal to the state board of tax appeals within thirty days after notice of the order or decision of the commission has been received by the party. Any party aggrieved by an order or decision of the state board of tax appeals under this section may appeal the order or decision to tax court but must commence such action within thirty days after notice of the order or decision of the state board has been received by the party.

H. Following an agreement among the cities or towns involved as to which city or town has jurisdiction over transaction privilege taxation on a transaction or following a final determination by the municipal tax code commission, the state board of tax appeals or the tax court that a city or town is entitled to collect such taxes, and following written notification to the taxpayer, the taxpayer shall thereafter pay transaction privilege taxes on similar transactions to that city or town.

I. In this section:

1. "Appropriate city or town" means a city or town in this state either:

   (a) In which the business sales office which generated the taxable transaction is located.

   (b) In which the purchaser resides, is located or is situated at the time of the transaction.
(c) Which imposes or claims the right to impose a transaction privilege tax on the transaction in question under its ordinance.

2. "Transaction privilege tax" means a municipal transaction privilege license tax, use tax or similar tax and includes for purposes of this section any penalty assessed by a city or town for nonpayment, delinquent payment or failure to timely report or file a return, and any interest assessed because of late payment of taxes.
41-1003. **Required rule making**

Each agency shall make rules of practice setting forth the nature and requirements of all formal procedures available to the public.
CREDIT ENHANCEMENT ELIGIBILITY BOARD
Title 7, Chapter 8, Articles 1 & 2
GOVERNOR’S REGULATORY REVIEW COUNCIL

ATTORNEY MEMORANDUM - FIVE-YEAR REVIEW REPORT

MEETING DATE:  September 7, 2022

TO:        Members of the Governor’s Regulatory Review Council (Council)

FROM:      Council Staff

DATE:      August 19, 2022

SUBJECT:   CREDIT ENHANCEMENT ELIGIBILITY BOARD

Title 7, Chapter 8, Articles 1 & 2

Summary

This Five-Year Review Report (5YRR) from the Credit Enhancement Eligibility Board (Board) relates to two (2) rules in Title 7, Chapter 8, Articles 1 and 2. Specifically, R7-8-101 establishes and administers Achievement District Schools program. R7-8-201 establishes and administers the Arizona Public School Credit Enhancement program (Program). The Arizona Public School Credit Enhancement program was enacted to allow qualifying public schools to borrow against the State’s credit rating, freeing financial capacity by lowering the amount schools pay on their interest. The provisions in both articles outline the required information needed at the time of applying as well as specifying required financial provisions to uphold the Program’s credit rating.

The Board did not propose a course of action in the last 5YRR for these rules.

Proposed Action

The Board proposes to amend these rules to change all statutory references throughout the rules which cite Arizona Revised Statutes Title 15. The Board indicates the statutes have since been moved to Title 41.
1. **Has the agency analyzed whether the rules are authorized by statute?**

   The Board cites both general and specific statutory authority for the rules.

2. **Summary of the agency’s economic impact comparison and identification of stakeholders:**

   The Board states the Arizona Public School Credit Enhancement Program (Program) was enacted to allow qualifying public schools to borrow against the State’s credit rating, freeing financial capacity by lowering the amount schools pay on their interest. The Board indicates OSPB consulted with the credit rating agency Standards and Poor’s (S&P) before establishing the Board's application and evaluation process. On May 5th, 2017, S&P rated the Program at “AA-.” The report cited five key credit features responsible for the credit rating:

   1. Establishment of the program by state statute;
   2. A limit to the amount of bonds that can be guaranteed;
   3. A formal application process to determine participant eligibility;
   4. A formal process that outlines disbursements in the event of a potential debt service deficiency; and
   5. Projected sufficient overcollateralization to provide rating stability.

   The Board states R7-8-101 and R7-8-201 establish the necessary rules and procedures to ensure that the Program maintains the credit rating of “AA-.” More specifically, the provisions in both articles outline the required information needed at the time of applying as well as specifying required financial provisions to uphold the Program’s credit rating. The Board states the rules’ probable benefits outweigh the probable costs by maintaining the Program’s credit rating which allows qualifying public schools to borrow against the Program’s credit rating. The Board indicates this has allowed the qualifying public schools to save more than $61 million in total, allowing greater financial capacity to better serve their students. The increased financial capacity to expand facilities and services is the economic impact of these rules.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

   The Board states the rules’ probable benefits outweigh the probable costs by maintaining the Program’s credit rating which allows qualifying public schools to borrow against the Program’s credit rating. The Board indicates this has allowed the qualifying public schools to save more than $61 million in total, allowing greater financial capacity to better serve their students. The increased financial capacity to expand facilities and services is the economic impact of these rules.

4. **Has the agency received any written criticisms of the rules over the last five years?**

   The Board indicates they have not received any written criticisms of the rules over the last five years.
5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**

   The Board indicates the rules are clear, concise, and understandable.

6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**

   The Board indicates the statutory references throughout the rules cite Arizona Revised Statutes Title 15. The statutes have since been moved to Title 41 and must be amended.

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**

   The Board indicates the rules are effective in achieving their objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**

   The Board indicates the rules are enforced as written.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

   The Board indicates it is unaware of any corresponding federal law that governs these rules.

10. **For rules adopted after July 29, 2010, do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

    Not applicable. The Board does not issue permits, licenses, or agency authorizations.

11. **Conclusion**

    This 5YRR from the Board relates to two (2) rules in Title 7, Chapter 8, Articles 1 and 2. Specifically, R7-8-101 establishes and administers Achievement District Schools program. R7-8-201 establishes and administers the Arizona Public School Credit Enhancement program (Program). The Arizona Public School Credit Enhancement program was enacted to allow qualifying public schools to borrow against the State’s credit rating, freeing financial capacity by lowering the amount schools pay on their interest. The provisions in both articles outline the required information needed at the time of applying as well as specifying required financial provisions to uphold the Program’s credit rating.

    The Board proposes to amend these rules to change all statutory references throughout the rules which cite Arizona Revised Statutes Title 15. The Board indicates the statutes have since been moved to Title 41.

    Council staff recommends approval of this report.
June 20, 2022

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: [Credit Enhancement Eligibility Board, Title 7, Chapter 8, Articles 1 & 2, Five Year Review Report]

Dear Nicole Sornsin:

Please find enclosed the Five Year Review Report of Credit Enhancement Eligibility Board for Title 7, Chapter 8, Article 1 & 2 which is due on June 28, 2022.

The Credit Enhancement Eligibility Board hereby certifies compliance with A.R.S. 41-1091.

For questions about this report, please contact Alec Eulano at (602) 486-9313 or aeulano@az.gov.

Sincerely,

Matt Gress
Authorization of the rule by existing statutes

A.R.S. § 41-5853(B)(9)

The objective of each rule:

<table>
<thead>
<tr>
<th>Rule</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>R7-8-101</td>
<td>Establishes and administers Achievement District Schools program.</td>
</tr>
<tr>
<td>R7-8-201</td>
<td>Establishes and administers the Arizona Public School Credit Enhancement program.</td>
</tr>
</tbody>
</table>

Are the rules effective in achieving their objectives? Yes ☑ No ___

Are the rules consistent with other rules and statutes? Yes ___ No ☑

Statutory references throughout the rules cite Arizona Revised Statutes Title 15. The statutes have since been moved to Title 41.

Are the rules enforced as written? Yes ☑ No ___

Are the rules clear, concise, and understandable? Yes ☑ No ___

Has the agency received written criticisms of the rules within the last five years? Yes ___ No ☑

Economic, small business, and consumer impact comparison:

The Arizona Public School Credit Enhancement Program (Program) was enacted to allow qualifying public schools to borrow against the State’s credit rating, freeing financial capacity by lowering the amount schools pay on their interest. OSPB consulted with the credit rating agency Standards and Poor’s (S&P) before establishing the Board's application and evaluation process. On May 5th, 2017, S&P rated the Program at “AA-.“ The report cited five key credit features responsible for the credit rating:

a) Establishment of the program by state statute;

b) A limit to the amount of bonds that can be guaranteed;

c) A formal application process to determine participant eligibility;

d) A formal process that outlines disbursements in the event of a potential debt service deficiency; and
e) Projected sufficient overcollateralization to provide rating stability.

R7-8-101 and R7-8-201 establish the necessary rules and procedures to ensure that the Program maintains the credit rating of “AA-.” More specifically, the provisions in both articles outline the required information needed at the time of applying as well as specifying required financial provisions to uphold the Program’s credit rating. The rules’ probable benefits outweigh the probable costs by maintaining the Program’s credit rating which allows qualifying public schools to borrow against the Program’s credit rating. This has allowed the qualifying public schools to save more than $61 million in total, allowing greater financial capacity to better serve their students. The increased financial capacity to expand facilities and services is the economic impact of these rules.

9. **Has the agency received any business competitiveness analyses of the rules?**
   Yes [ ] No [✓]

10. **Has the agency completed the course of action indicated in the agency’s previous five-year-review report?**
    N/A

11. **A determination that the probable benefits of the rule outweigh within this state the probable costs of the rule, and the rule imposes the least burden and costs to regulated persons by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective:**
    The rules’ probable benefits outweigh the probable costs by maintaining the Program’s credit rating which allows qualifying public schools to borrow against the Program’s credit rating. This has allowed the qualifying public schools to save more than $61 million in total, allowing greater financial capacity to better serve their students. The increased financial capacity to expand facilities and services is the economic impact of these rules.

12. **Are the rules more stringent than corresponding federal laws?**
    Yes [ ] No [✓]

    The Program is unaware of any corresponding federal law that governs these rules.
For rules adopted after July 29, 2010 that require the issuance of a regulatory permit, license, or agency authorization, whether the rules are in compliance with the general permit requirements of A.R.S. § 41-1037 or explain why the agency believes an exception applies:

N/A, the Credit Enhancement Eligibility Board does not issue permits, licenses, or agency authorization.

13. **Proposed course of action**

Remove all statutory references that cite Arizona Revised Statues Title 15. The relevant statutes have since been moved to Title 41. Please see the attached and proposed edits in the following pages.
THE ARIZONA ADMINISTRATIVE CODE

Within the stated calendar quarter, this Chapter contains all rules made, amended, repealed, renumbered, and recodified; or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor's Regulatory Review Council or the Attorney General's Office; or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information.

Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Title 7. Education

Chapter 8. Achievement District Schools

Supplement 17-1

Sections, Parts, Exhibits, Tables or Appendices modified
R7-8-101 and R7-8-201

New Chapter
REPLACE with Supp. 17-1

Pages: n/a
Pages: 1 - 5

The agency's contact person who can answer questions about rules in Supp. 17-1:

Agency: Achievement District Schools
Name: Dawn Wallace
Address: 1700 W. Washington St., Suite 503
Telephone: (602) 542-3438
Email: ksorensen@az.leg

Disclaimer: Please be advised the person listed is the contact of record as submitted in the rulemaking package for this supplement. The contact and other information may change and is provided as a public courtesy.
PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
PUBLIC SERVICES DIVISION
March 31, 2017

RULES
A.R.S. § 41-1001(17) states: “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE
The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions. Virtually everything in your life is affected in some way by rules published in the Arizona Administrative Code, from the quality of air you breathe to the licensing of your dentist. This chapter is one of more than 230 in the Code compiled in 21 Titles.

ADMINISTRATIVE CODE SUPPLEMENTS
Rules filed by an agency to be published in the Administrative Code are updated quarterly. Supplement release dates are printed on the footers of each chapter:

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2017 is cited as Supp. 17-1.

HOW TO USE THE CODE
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

ARTICLES AND SECTIONS
Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering system separated into subsections.

HISTORICAL NOTES AND EFFECTIVE DATES
Historical notes inform the user when the last time a Section was updated in the Administrative Code. Be aware, since the Office publishes each quarter by entire chapters, not all Sections are updated by an agency in a supplement release. Many times just one Section or a few Sections may be updated in the entire chapter.

ARIZONA REVISED STATUTE REFERENCES
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES
Arizona Session Law references in the introduction of a chapter can be found at the Secretary of State’s website, www.azsos.gov/services/legislative-filings.

EXEMPTIONS FROM THE APA
It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency's exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the pre-amble of rulemaking. The preamble is published in the Arizona Administrative Register online at www.azsos.gov/rules, click on the Administrative Register link.

In the Administrative Code the Office includes editor’s notes at the beginning of a chapter indicating that certain rulemaking Sections were made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR
If you are researching rules and come across rescinded chapters on a different paper color, this is because the agency filed a Notice of Exempt Rulemaking. At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

PERSONAL USE/COMMERCIAL USE
This chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

Public Services managing rules editor, Rhonda Paschal, assisted with the editing of this chapter.
TITLE 7. EDUCATION

CHAPTER 8. ACHIEVEMENT DISTRICT SCHOOLS

Editor’s Note: On November 29, 2016, the Public School Credit Enhancement Board conducted a public meeting where proposed rules were presented. At this time, the Board authorized staff to initiate the exempt rulemaking process and collect public comments for 30 days on proposed rules. On February 7, 2017, the Board approved the final rules which were published in the Arizona Administrative Register at 23 A.A.R. 661. Because the public was able to comment on the rules, the Office of the Secretary of State considers the rules filed as a Notice of Final Exempt Rulemaking.

ARTICLE 1. ACHIEVEMENT DISTRICT SCHOOL QUALIFICATIONS

Section R7-8-101. Achievement District Schools ...................... 2

ARTICLE 2. CREDIT ENHANCEMENT

Section R7-8-201. Arizona Public School Credit Enhancement Program ......................................................... 2
ARTICLE 1. ACHIEVEMENT DISTRICT SCHOOL QUALIFICATIONS

R7-8-101. Achievement District Schools
A. Authority. This rule is adopted pursuant to A.R.S. § 41-15-58412141(9).
B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 129, Laws of 2016, to administer the Achievement District Schools program.
C. Scope.
1. The scope of this Rule is the scope of A.R.S. Title 48, chapter 516, article 10 as it relates to Achievement District Schools. This rule is applicable to any district public school or charter public school operating in the State of Arizona that seeks qualification as an Achievement District School.
2. The statutory authority for this rule, A.R.S. Title 41-15, chapter 5146, article 10, does not provide for exemptions therefrom for person or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.
D. Repeal. This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.
E. Definitions
1. “Achievement District School” is any district public school or charter public school operating in the State of Arizona that meets all of the requirements set forth in A.R.S. § 41-15-58512141(1B) and that has applied for and has been designated by the Board as an Achievement District School.
2. “Applicant” means a School that is applying to become an Achievement District School, either directly or through its charter holder or operator or school district.
3. “Application” means an application for designation as an Achievement District School.
4. “Board” has the meaning of A.R.S. § 41-15-58522141(2).
5. “School” means a district public school or a charter public school that qualifies as a “school” pursuant to section 15-101(22).
6. “Underperforming” school means a school that has received a letter grade of C, D or F pursuant to A.R.S. § 15-241, or the equivalent under any replacement school evaluation system.
7. “Unaffiliated” means two entities that do not have any common ownership or control and are not under the control or ownership of the same entity.
F. Achievement District Schools - Application
1. A School seeking designation as an Achievement District School, pursuant to A.R.S. § 41-15-58412141, shall file an Application with the Board on Form A, which may be modified from time to time by the Board. The Application may be submitted either in paper format or electronically through the Governor’s Office of Education website.
2. Applications failing to comply with the requirements of A.R.S. § 41-15-58412144 shall be denied without prejudice to the subsequent filing by such School of an application complying with such requirements.
3. The accuracy and completeness of the information contained in an Application shall be certified to by the Chief Executive Officer or Chief Financial Officer of the School. Electronic Applications shall include a section for the provision of an electronic signature.
G. Achievement District Schools - Application Criteria. In completing Applications, Applicants must explain or provide the following information:
1. For proving receipt of a letter grade of A, or an equivalent successor classification, pursuant to A.R.S. § 41-15-58412141(9), certification that the School has received such grade at the time of submitting the Application. Charter public schools shall also provide certification that they are in material compliance with all requirements and their charter is not subject to revocation.
2. For the proven instructional strategies and curricula that demonstrate high academic outcomes required by A.R.S. § 41-15-58412141(9), a short narrative describing the School’s strategies that may include the School’s core programs, areas of instruction, pedagogy utilized and educational philosophies.
3. For verifiable enrollment demand required by A.R.S. § 41-15-58412141(6), certification that the School has demonstrated enrollment demand, such as a wait list or open enrollment demand, including the methodology used to evaluate enrollment demand.
4. For a sound financial plan that contemplates operational costs and future enrollment growth, required by A.R.S. § 41-15-2141(4), a letter from an Unaffiliated and Underperforming school that confirms the applicant School’s commitment and that identifies the areas of support being or to be provided.
6. Pursuant to A.R.S. § 41-15-2141(6), Applicants shall also provide information concerning any poverty indicators of its student population, including the ratio of students eligible for a free or reduced cost lunch program.
H. Achievement District Schools – Evaluation of Applications
1. Applications shall be reviewed to confirm that all required information has been received and the application is administratively complete. Within 30 days of submission of an application, the Applicant will be notified of any deficiencies in the Application.
2. Once an Application is determined to be administratively complete, the Board shall evaluate each Application and either approve or deny the Application within 60 days of this determination.
3. The Board shall meet no less than once every other month to decide upon Applications and for the conduct of any and all other business before the Board. The Board is authorized to call additional meetings in order to evaluate Applications or conduct other business and to cancel meetings if there is no business pending before the Board.
4. Applicants shall be notified of the Board’s decision to grant or deny Achievement District School status within 10 business days of the Board’s decision in writing, either by letter, facsimile or electronic mail.

Historical Note
New Section made by final exempt rulemaking at 23 A.A.R. 661, effective March 1, 2017 (Supp. 17-1).

ARTICLE 2. CREDIT ENHANCEMENT

R7-8-201. Arizona Public School Credit Enhancement Program
A. Authority. This rule is adopted pursuant to A.R.S. § 45-215341-5852(A)(B)(9).
B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 129, Laws of 2016, to administer the Arizona Public School Credit Enhancement Program.

C. Scope.
1. The scope of this Rule is the scope of A.R.S. Title 1541, chapter 4656, article 11 as it relates to Arizona public school credit enhancement. This rule is applicable to any district public school or charter public school operating in the State of Arizona that applies for a Guaranteed Financing from the Board.
2. The statutory authority for this rule, A.R.S. Title 4541, chapter 4656, article 11, does not provide for exemptions therefor from or persons or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.

D. Repeal. This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.

E. Definitions
1. “Achievement District School” has the meaning of A.R.S. § 1541-21545851(B)(1).
2. “Applicant” means an Achievement District School that has submitted an Application to the Board, either directly or through its charter holder or operator or school district.
3. “Application” means an application for a Guaranteed Financing submitted by an Achievement District School to the Board.
4. “Board” has the meaning of A.R.S. § 1541-215458512.
5. “Guaranteed Financing” has the meaning of A.R.S. § 1541-215458514.
6. “School” means a district public school or a charter public school that qualifies as a “school” pursuant to section 15-101(22).

F. Arizona Public School Credit Enhancement – Application
1. An Achievement District School seeking a Guaranteed Financing, pursuant to A.R.S. § 1541-21555855, shall file an Application with the Board on Form B, which may be modified from time to time by the Board. In the alternative, a School may apply to become an Achievement District School and for a Guaranteed Financing contemporaneously by filing an Application with the Board on Form C. Applications may be submitted either in paper format or electronically through the Governor’s Office of Education website.
2. Applications failing to comply with the requirements of A.R.S. § 4145-582455 shall be denied without prejudice to the subsequent filing by such School of an application complying with such requirements.
3. The accuracy and completeness of information in an Application shall be certified to by the Chief Executive Officer or Chief Financial Officer of the School. Electronic Applications shall include a section for the provision of an electronic signature.

G. Arizona Public School Credit Enhancement - Application Criteria. In completing Applications, Applicants must explain or provide the following information:
1. Unless the Application is a combined Application, for proof as approval as an Achievement District School, certification that the information previously submitted to the Board in the Applicant’s Achievement District School application pursuant to A.R.S. § 1541-582455(B)(1) is still accurate in all respects.
2. For exhibited sustainability of the Achievement District School’s financial operations, in addition to the items required by A.R.S. § 1541-582455(B)(2), the following documents:
   a. At least the two immediate past years’ audited financial statements. The audits must include an unqualified opinion and may not identify any “going concern” issues. If an audit has not been completed for the most recent year, internally generated financial statements, including at least a statement of revenues and expenditures or a balance sheet by line-item or category totals that align with the submitted financial statements must be provided. The Board may request an additional year of audited financials.
   b. The School’s current year budget with line items or category totals that align with the submitted audited financial statements. For applications made after the first quarter of a fiscal year, a current balance sheet and year-to-date revenues and expenditures compared to budget by budget category.
   c. Additionally, for charter public schools:
      i. The Applicant must include a listing of the names, positions and experience of the charter public school’s corporate board of directors and its senior staff.
      ii. The Applicant must include information on any material or substantial lawsuits, threatened or potential litigation brought by any outside party, either currently or in the past three years, or any failure to have its charter re-approved, if any.
      iii. The Applicant must include a projection of revenues, expenditures and net cash flows for the ensuing three-year period.
      iv. The Applicant shall also provide student enrollment statistics by grade for each grade level served, for the shorter of either the period the School has been in operation or for the most recent five years, for the current year, and projected student enrollment for the next five years.
      v. The Applicant must demonstrate sufficient liquidity as evidenced by providing a statement showing the School has either:
         (1) At least 45 days unrestricted cash on hand based on the most recently completed fiscal year and for each of the years under the projections provided; or
         (2) At least 30 days cash on hand based on the most recently completed fiscal year, a net increase in cash and cash equivalents for such year compared to the prior fiscal year, and that its days cash on hand is projected to increase to 45 days cash on hand within two fiscal years based on the projected projections.
      vi. If the Applicant has outstanding debt that is rated by a municipal bond rating agency, documentation showing the rating.
      vii. A list of all of its current outstanding debts, accompanied by a statement that the Applicant is not currently in default on any outstanding debt.
3. For a charter Achievement District School’s demonstrated experience in operating and managing charter public schools with high academic outcomes for at least two consecutive years, as required by A.R.S. § 1541-582455(B)(3), a narrative history covering at least the two
most recent years of the Applicant’s historical academic outcomes and operations.

4. For information regarding the proposed Guaranteed Financing, the following information:
   a. The planned timing of such financing, a schedule of estimated sources and uses of funds for such financing, the expected principal and interest payment dates and amounts by payment date for such financing, and plans for funding reserves, if any.
   b. A description of what the Guaranteed Financing will be used for, a description of how the Guaranteed Financing will reduce or impact the Applicant’s enrollment demand, whether the Guaranteed Financing will be a refinance of existing debt obligations, and if so, the estimated savings of the refinance and how the Applicant proposes to spend the monies saved as a result of the refinance.

5. For identification of any property being pledged as collateral, as required by A.R.S. § 4115-582155(B)(6), the Applicant must disclose whether any property to be financed and secured by a Guaranteed Financing will be owned or leased by the Applicant or, for charter public schools, the Applicant or its charter holder. Real property being pledged as collateral shall be identified by physical address, and a copy of an independent appraisal of the property that reflects current valuation within 90 days of submission, along with a copy of the lease for any leased collateral real property, must be provided to the Board not less than 30 calendar days and not more than 60 calendar days before the issuance of the Guaranteed Financing.

6. Pursuant to A.R.S. § 4115-582155(B)(7), information concerning the Applicant’s teacher turnover rate and the results from the immediate prior two years of any parent and/or teacher satisfaction surveys conducted by the Applicant. For charter public schools, the Applicant shall also disclose whether any personal benefit will inure to any employee of the School or school operator or an immediate relative, including a parent, spouse, sibling or child, of any such employee or operator.

II. Arizona Public School Credit Enhancement – Required Financial Provisions for Guaranteed Financings. In order for the Board to approve a Guaranteed Financing, the proposed project must meet the following terms and requirements:

1. The debt service on the Guaranteed Financing may include interest-only payments for no more than two fiscal years following the fiscal year of issuance and must include level annual total principal and interest payments thereafter.

2. The Guaranteed Financing must be fully amortizing over a period not to exceed 35 years.

3. For non-general obligation, tax-supported obligations, the Guaranteed Financing must meet one of the following debt service coverage ratio requirements as estimated at the time of the Application and upon issuance of the Guaranteed Financing:
   a. The ratio of the net cash flow (i.e. total revenues less operating expenses excluding debt or lease payments on land and facilities and non-cash expenses) for the most recently completed fiscal year to the maximum annual combined payments on existing debt, leases of land and facilities and the Guaranteed Financing must be at least 110%; or
   b. The ratio of the net cash flow as defined above for the most recently completed fiscal year to the combined payments on existing debt and leases, but excluding the Guaranteed Financing, must be at least 110%, and the ratio of projected net cash flow as defined above for each of the subsequent five fiscal years to the combined maximum annual payments on existing debt, leases of land and facilities, and the Guaranteed Financing must be at least 110%.

4. Tax Base/Collections – District Public Schools
   a. For district public school Applicants using a district’s voted general obligation bond authorization for a Guaranteed Financing, property tax collections for the three most recent fiscal years must average 90% or more.
   b. For district public school Applicants that will not use the property tax base for a Guaranteed Financing, the Applicant must identify the authorized source of payment for the Guaranteed Financing and provide evidence of adequate ongoing dedicated or pledged revenues and budget capacity to service the minimum annual payments to be due under the Guaranteed Financing and any other parity obligations at 110% of the annual payments due.

5. Guaranteed Financings Secured by Real Property
   a. If the Guaranteed Financing will involve property or facilities that will be pledged as collateral for the Guaranteed Financing, the Applicant must provide an independent appraisal to the Board dated not less than 30 calendar days and not more than 60 calendar days before the issuance of the Guaranteed Financing. For Guaranteed Financings for a Guaranteed Financing and any other parity obligations at 110%.
   b. The Applicant must identify or describe the ownership status of the property/facilities that will be funded by the Guaranteed Financing, including whether the property will be owned in fee simple, will be leased, or will be subject to some other control or ownership agreement.
   c. For property being leased, the Applicant must provide a copy of the lease and identify the term, renewal options, assignment rights and the payment schedule.
   d. For a Guaranteed Financing that will require construction of new facilities or major renovations to existing facilities of $1,000,000.00 or more, the Applicant must acknowledge that the Guaranteed Financing is contingent upon execution of a guaranteed maximum price contract or other acceptable
mechanism ensuring project completion, along with a requirement for the contractor to provide a completion bond or its equivalent.

6. Refinancing Guaranteed Financings – for Guaranteed Financings that will refinance a prior existing debt obligation for which the originally pledged property will be pledged as collateral for the Guaranteed Financing, payments on the Guaranteed Financing may not be greater in any fiscal year than the scheduled payments on the prior obligations, and the savings to be generated on a present value basis must equal or exceed 5% of the principal amount of the refinanced obligations.

I. Arizona Public School Credit Enhancement – Evaluation of Applications

1. Applications shall be reviewed to confirm that all required information has been received and the Application is administratively complete. Within 30 days of submission of an Application, the Applicant will be notified of any deficiencies in the Application.

2. Once an Application is determined to be administratively complete, the Board shall evaluate each Application and either approve or deny the Application within 60 days of this determination.

3. In deciding whether to approve or deny an Application, the Board may give preference to:
   a. Proposed Guaranteed Financings that fund projects in low socioeconomic areas or to serve low socioeconomic student populations;
   b. Proposed Guaranteed Financings based on the geographic distribution of Guaranteed Financings throughout the state;
   c. Proposed Guaranteed Financings that fund new classrooms or facilities to meet established enrollment demand; and
   d. Proposed Guaranteed Financings that will maintain the overall program requirements imposed by A.R.S. § 4115-582455(C).

4. The Board shall meet no less than once every other month to decide upon Applications and for the conduct of any and all other business before the Board. The Board is authorized to call additional meetings in order to evaluate Applications or conduct other business and to cancel meetings if there is no business pending before the Board.

5. Applicants shall be notified of the Board’s decision to grant or deny credit enhancement to a proposed Guaranteed Financing within 10 business days of the Board’s decision in writing, either by letter, facsimile or electronic mail.

J. Deadline for Issuance of Guaranteed Financing – Once the Applicant is awarded initial approval for a Guaranteed Financing, the Applicant must issue the Guaranteed Financing within 120 days of the date of the letter granting approval for the Guaranteed Financing. The initial approval for the Guaranteed Financing will expire at the end of the 120-day period. The Applicant may request an extension for an additional 60 days by submitting a written request to the Board setting forth the reasons for the requested extension, before the expiration of the initial 120-day period.

K. Arizona Public School Credit Enhancement Participation Fee – In setting participation fees pursuant to A.R.S. § 4115-582455(E), the Board shall consider, among other things, the value and type of collateral being pledged, the term of the Guaranteed Financing, projected savings by the School through the Guaranteed Financing, the rating of the proposed Guaranteed Financing without regard to the credit enhancement to be provided, the overall amount of the Guaranteed Financing and whether the Achievement District School is a district public school or a charter public school. The Board may establish the participation fee as a percentage of the Guaranteed Financing or otherwise, depending on the specific terms of the Guaranteed Financing.

**Historical Note**

New Section made by final exempt rulemaking at 23 A.A.R. 661, effective March 1, 2017 (Supp. 17-1).
Replacement Check List

For rules filed within the
1st Quarter
January – March 31, 2017

THE ARIZONA ADMINISTRATIVE CODE

Within the stated calendar quarter, this Chapter contains all rules made, amended, repealed, renumbered, and recodified; or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor’s Regulatory Review Council or the Attorney General’s Office; or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

Title 7. Education

Chapter 8. Achievement District Schools

Supplement 17-1

Sections, Parts, Exhibits, Tables or Appendices modified
R7-8-101 and R7-8-201

New Chapter
Pages: n/a

REPLACE with Supp. 17-1
Pages: 1 - 5

The agency’s contact person who can answer questions about rules in Supp. 17-1:
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Disclaimer: Please be advised the person listed is the contact of record as submitted in the rulemaking package for this supplement. The contact and other information may change and is provided as a public courtesy.
PREFACE

Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
PUBLIC SERVICES DIVISION
March 31, 2017

RULES
A.R.S. § 41-1001(17) states: “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE
The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions. Virtually everything in your life is affected in some way by rules published in the Arizona Administrative Code, from the quality of air you breathe to the licensing of your dentist. This chapter is one of more than 230 in the Code compiled in 21 Titles.

ADMINISTRATIVE CODE SUPPLEMENTS
Rules filed by an agency to be published in the Administrative Code are updated quarterly. Supplement release dates are printed on the footers of each chapter:

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2017 is cited as Supp. 17-1.

HOW TO USE THE CODE
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

ARTICLES AND SECTIONS
Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering system separated into subsections.

HISTORICAL NOTES AND EFFECTIVE DATES
Historical notes inform the user when the last time a Section was updated in the Administrative Code. Be aware, since the Office publishes each quarter by entire chapters, not all Sections are updated by an agency in a supplement release. Many times just one Section or a few Sections may be updated in the entire chapter.

ARIZONA REVISED STATUTE REFERENCES
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES
Arizona Session Law references in the introduction of a chapter can be found at the Secretary of State’s website, www.azsos.gov/services/legislative-filings.

EXEMPTIONS FROM THE APA
It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the Arizona Administrative Register online at www.azsos.gov/rules, click on the Administrative Register link.

In the Administrative Code the Office includes editor’s notes at the beginning of a chapter indicating that certain rulemaking Sections were made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR
If you are researching rules and come across rescinded chapters on a different paper color, this is because the agency filed a Notice of Exempt Rulemaking. At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

PERSONAL USE/COMMERCIAL USE
This chapter is posted as a public courtesy online, and is for private use only. Those who wish to use the contents for resale or profit should contact the Office about Commercial Use fees. For information on commercial use fees review A.R.S. § 39-121.03 and 1 A.A.C. 1, R1-1-113.

Public Services managing rules editor, Rhonda Paschal, assisted with the editing of this chapter.
TITLE 7. EDUCATION

CHAPTER 8. ACHIEVEMENT DISTRICT SCHOOLS

Editor’s Note: On November 29, 2016, the Public School Credit Enhancement Board conducted a public meeting where proposed rules were presented. At this time, the Board authorized staff to initiate the exempt rulemaking process and collect public comments for 30 days on proposed rules. On February 7, 2017, the Board approved the final rules which were published in the Arizona Administrative Register at 23 A.A.R. 661. Because the public was able to comment on the rules, the Office of the Secretary of State considers the rules filed as a Notice of Final Exempt Rulemaking.

ARTICLE 1. ACHIEVEMENT DISTRICT SCHOOL QUALIFICATIONS

Section R7-8-101. Achievement District Schools .............................. 2

ARTICLE 2. CREDIT ENHANCEMENT

Section R7-8-201. Arizona Public School Credit Enhancement Program ................................. 2
ARTICLE 1. ACHIEVEMENT DISTRICT SCHOOL QUALIFICATIONS

R7-8-101. Achievement District Schools
A. Authority. This rule is adopted pursuant to A.R.S. § 15-2153(B)(9).
B. Purpose. The purpose of this rule is to implement the legislative intent, as expressed in Chapter 129, Laws of 2016, to administer the Achievement District Schools program.
C. Scope. 1. The scope of this Rule is the scope of A.R.S. Title 15, chapter 16, article 10 as it relates to Achievement District Schools. This rule is applicable to any district public school or charter public school operating in the State of Arizona that seeks qualification as an Achievement District School.
2. The statutory authority for this rule, A.R.S. Title 15, chapter 16, article 10, does not provide for exemptions therefrom for person or agents of persons subject thereto, and no such exemption is intended or should be presumed by this rule or any provision thereof.
D. Repeal. This rule does not repeal any known prior rule, memorandum, bulletin, directive or opinion on this subject matter. If such prior rule or directive exists and is in conflict herewith, the same is repealed hereby.
E. Definitions
1. “Achievement District School” is any district public school or charter public school operating in the State of Arizona that meets all of the requirements set forth in A.R.S. § 15-2141(B) and that has applied for and has been designated by the Board as an Achievement District School.
2. “Applicant” means a School that is applying to become an Achievement District School, either directly or through its charter holder or operator or school district.
3. “Application” means an application for designation as an Achievement District School.
4. “Board” has the meaning of A.R.S. § 15-2151(2).
5. “School” means a district public school or a charter public school that qualifies as a “school” pursuant to section 15-101(22).
6. “Underperforming” school means a school that has received a letter grade of C, D or F pursuant to A.R.S. § 15-241, or the equivalent under any replacement school evaluation system.
7. “Unaffiliated” means two entities that do not have any common ownership or control and are not under the control or ownership of the same entity.
F. Achievement District Schools - Application
1. A School seeking designation as an Achievement District School, pursuant to A.R.S. § 15-2141, shall file an Application with the Board on Form A, which may be modified from time to time by the Board. The Application may be submitted either in paper format or electronically through the Governor’s Office of Education website.
2. Applications failing to comply with the requirements of A.R.S. § 15-2141 shall be denied without prejudice to the subsequent filing by such School of an application complying with such requirements.
3. The accuracy and completeness of the information contained in an Application shall be certified to by the Chief Executive Officer or Chief Financial Officer of the School. Electronic Applications shall include a section for the provision of an electronic signature.
G. Achievement District Schools - Application Criteria. In completing Applications, Applicants must explain or provide the following information:
1. For proving receipt of a letter grade of A, or an equivalent successor classification, pursuant to A.R.S. § 15-2141(B)(1), certification that the School has received such grade at the time of submitting the Application. Charter public schools shall also provide certification that they are in material compliance with all requirements and their charter is not subject to revocation.
2. For the proven instructional strategies and curricula that demonstrate high academic outcomes required by A.R.S. § 15-2141(B)(2), a short narrative describing the School’s strategies that may include the School’s core programs, areas of education, pedagogy utilized and educational philosophies.
3. For verifiable enrollment demand required by A.R.S. § 15-2141(B)(3), certification that the School has demonstrated enrollment demand, such as a wait list or open enrollment demand, including the methodology used to evaluate enrollment demand.
4. For a sound financial plan that contemplates operational costs and future enrollment growth, required by A.R.S. § 15-2141(B)(4), the Applicant’s annual audited financial statements for the immediate past fiscal year, or if audited financial statements are not yet available, unaudited financial statements for the immediate past fiscal year, as well as year-to-date actual expenditures as compared to budget.
5. For a commitment to provide technical assistance to an Underperforming school in the State, as required by A.R.S. § 15-2141(B)(5), a letter from an Unaffiliated and Underperforming school that confirms the applicant School’s commitment and that identifies the areas of support being or to be provided.
6. Pursuant to A.R.S. § 15-2141(B)(6), Applicants shall also provide information concerning any poverty indicators of its student population, including the ratio of students eligible for a free or reduced cost lunch program.
H. Achievement District Schools – Evaluation of Applications
1. Applications shall be reviewed to confirm that all required information has been received and the application is administratively complete. Within 30 days of submission of an application, the Applicant will be notified of any deficiencies in the Application.
2. Once an Application is determined to be administratively complete, the Board shall evaluate each Application and either approve or deny the Application within 60 days of this determination.
3. The Board shall meet no less than once every other month to decide upon Applications and for the conduct of any and all other business before the Board. The Board is authorized to call additional meetings in order to evaluate Applications or conduct other business and to cancel meetings if there is no business pending before the Board.
4. Applicants shall be notified of the Board’s decision to grant or deny Achievement District School status within 10 business days of the Board’s decision in writing, either by letter, facsimile or electronic mail.

Historical Note
New Section made by final exempt rulemaking at 23 A.A.R. 661, effective March 1, 2017 (Supp. 17-1).

ARTICLE 2. CREDIT ENHANCEMENT

R7-8-201. Arizona Public School Credit Enhancement Program
A. Authority. This rule is adopted pursuant to A.R.S. § 15-2153(B)(9).
B. Purpose. The purpose of this rule is to implement the legisla-
tive intent, as expressed in Chapter 129, Laws of 2016, to
administer the Arizona Public School Credit Enhancement
Program.

C. Scope.
   1. The scope of this Rule is the scope of A.R.S. Title 15,
      chapter 16, article 11 as it relates to Arizona public school
      credit enhancement. This rule is applicable to any district
      public school or charter public school operating in the
      State of Arizona that applies for a Guaranteed Financing
      from the Board.
   2. The statutory authority for this rule, A.R.S. Title 15,
      chapter 16, article 11, does not provide for exemptions
      therefrom for person or agents of persons subject thereto,
      and no such exemption is intended or should be presumed
      by this rule or any provision thereof.

D. Repeal. This rule does not repeal any known prior rule, memo-
    randum, bulletin, directive or opinion on this subject matter. If
    such prior rule or directive exists and is in conflict herewith,
    the same is repealed hereby.

E. Definitions
   1. “Achievement District School” has the meaning of
      A.R.S. § 15-2151(1).
   2. “Applicant” means an Achievement District School that
      has submitted an Application to the Board, either directly
      or through its charter holder or operator or school district.
   3. “Application” means an application for a Guaranteed
      Financing submitted by an Achievement District School
      to the Board.
   4. “Board” has the meaning of A.R.S. § 15-2151(2).
   5. “Guaranteed Financing” has the meaning of A.R.S. § 15-
      2151(4).
   6. “School” means a district public school or a charter pub-
      lic school that qualifies as a “school” pursuant to section
      15-101(22).

F. Arizona Public School Credit Enhancement – Application
   1. An Achievement District School seeking a Guaranteed
      Financing, pursuant to A.R.S. § 15-2155, shall file an
      Application with the Board on Form B, which may be
      modified from time to time by the Board. In the alterna-
      tive, a School may apply to become an Achievement Dis-
      trict School and for a Guaranteed Financing contemporaneously by filing an Application with the
      Board on Form C. Applications may be submitted either
      in paper format or electronically through the Governor’s
      Office of Education website.
   2. Applications failing to comply with the requirements of
      A.R.S. § 15-2155 shall be denied without prejudice to the
      subsequent filing by such School of an application compl-
      ying with such requirements.
   3. The accuracy and completeness of information in an
      Application shall be certified to by the Chief Executive
      Officer or Chief Financial Officer of the School. Elec-
      tronic Applications shall include a section for the provi-
      sion of an electronic signature.

G. Arizona Public School Credit Enhancement - Application Cri-
    teria. In completing Applications, Applicants must explain or
    provide the following information:
   1. Unless the Application is a combined Application, for
      proof as approval as an Achievement District School, cer-
      tification that the information previously submitted to the
      Board in the Applicant’s Achievement District School
      application pursuant to A.R.S. § 15-2155(B)(1) is still
      accurate in all respects.
   2. For exhibited sustainability of the Achievement District
      School’s financial operations, in addition to the items
      required by A.R.S. § 15-2155(B)(2), the following docu-
      ments:
      a. At least the two immediate past years’ audited finan-
         cial statements. The audits must include an unquali-
         fied opinion and may not identify any “going
         concern” issues. If an audit has not been completed
         for the most recent year, internally generated finan-
         cial statements, including at least a statement of rev-
         enues and expenditures or a balance sheet by line-
         item or category totals that align with the submitted
         financial statements must be provided. The Board
         may request an additional year of audited financials
      b. The School’s current year budget with line items or
         category totals that align with the submitted audited
         financial statements. For applications made after the
         first quarter of a fiscal year, a current balance sheet
         and year-to-date revenues and expenditures com-
         pared to budget by budget category.
      c. Additionally, for charter public schools:
         i. The Applicant must include a listing of the
            names, positions and experience of the charter
            public school’s corporate board of directors and
            its senior staff.
         ii. The Applicant must include information on any
            material or substantial lawsuits, threatened or
            potential litigation brought by any outside
            party, either currently or in the past three years,
            or any failure to have its charter re-approved, if
            any.
         iii. The Applicant must include a projection of rev-
            enues, expenditures and net cash flows for the
            ensuing three-year period.
         iv. The Applicant shall also provide student enroll-
            ment statistics by grade for each grade level
            served, for the shorter of either the period the School
            has been in operation or for the most
            recent five years, for the current year, and pro-
            jected student enrollment for the next five
            years.
         v. The Applicant must demonstrate sufficient
            liquidity as evidenced by providing a statement
            showing the School has either:
            (1) At least 45 days unrestricted cash on hand
                based on the most recently completed fis-
                cal year and for each of the years under the
                projections provided; or
            (2) At least 30 days cash on hand based on the
                most recently completed fiscal year, a net
                increase in cash and cash equivalents for
                such year compared to the prior fiscal
                year, and that its days cash on hand is pro-
                jected to increase to 45 days cash on hand
                within two fiscal years based on the pro-
                vided projections.
         vi. If the Applicant has outstanding debt that is
            rated by a municipal bond rating agency, docu-
            mentation showing the rating.
         vii. A list of all of its current outstanding debts,
            accompanied by a statement that the Applicant
            is not currently in default on any outstanding
            debt.
   3. For a charter Achievement District School’s demon-
      stratred experience in operating and managing charter
      public schools with high academic outcomes for at least
      two consecutive years, as required by A.R.S. § 15-
      2155(B)(3), a narrative history covering at least the two
most recent years of the Applicant’s historical academic outcomes and operations.

4. For information regarding the proposed Guaranteed Financing, the following information:
   a. The planned timing of such financing, a schedule of estimated sources and uses of funds for such financing, the expected principal and interest payment dates and amounts by payment date for such financing, and plans for funding reserves, if any.
   b. A description of what the Guaranteed Financing will be used for, a description of how the Guaranteed Financing will reduce or impact the Applicant’s enrollment demand, whether the Guaranteed Financing will be a refinance of existing debt obligations, and if so, the estimated savings of the refinance and how the Applicant proposes to spend the monies saved as a result of the refinance.

5. For identification of any property being pledged as collateral, as required by A.R.S. § 15-2155(B)(6), the Applicant must disclose whether any property to be financed and secured by a Guaranteed Financing will be owned or leased by the Applicant or, for charter public schools, the Applicant or its charter holder. Real property being pledged as collateral shall be identified by physical address, and a copy of an independent appraisal of the property that reflects current valuation within 90 days of submission, along with a copy of the lease for any leased collateral real property, must be provided to the Board not less than 30 calendar days and not more than 60 calendar days before the issuance of the Guaranteed Financing.

6. Pursuant to A.R.S. § 15-2155(B)(7), information concerning the Applicant’s teacher turnover rate and the results from the immediate prior two years of any parent and/or teacher satisfaction surveys conducted by the Applicant. For charter public schools, the Applicant shall also disclose whether any personal benefit will inure to any employee of the School or school operator or an immediate relative, including a parent, spouse, sibling or child, of any such employee or operator.

H. Arizona Public School Credit Enhancement – Required Financial Provisions for Guaranteed Financings. In order for the Board to approve a Guaranteed Financing, the proposed project must meet the following terms and requirements:

1. The debt service on the Guaranteed Financing may include interest-only payments for no more than two fiscal years following the fiscal year of issuance and must include level annual total principal and interest payments thereafter.

2. The Guaranteed Financing must be fully amortizing over a period not to exceed 35 years.

3. For non-general obligation, tax-supported obligations, the Guaranteed Financing must meet one of the following debt service coverage ratio requirements as estimated at the time of the Application and upon issuance of the Guaranteed Financing:
   a. The ratio of the net cash flow (i.e. total revenues less operating expenses excluding debt or lease payments on land and facilities and non-cash expenses) for the most recently completed fiscal year to the maximum annual combined payments on existing debt, leases of land and facilities and the Guaranteed Financing must be at least 110%; or
   b. The ratio of the net cash flow as defined above for the most recently completed fiscal year to the combined payments on existing debt and leases, but excluding the Guaranteed Financing, must be at least 110%, and the ratio of projected net cash flow as defined above for each of the subsequent five fiscal years to the combined maximum annual payments on existing debt, leases of land and facilities, and the Guaranteed Financing must be at least 110%. For this requirement, the projections must be accompanied by a report from an independent certified public accountant or a financial consultant with demonstrated expertise in public charter school financings confirming that the accountant or consultant has reviewed the Applicant’s projections and deems the projections to be fair and reasonable.

4. Tax Base/Collections – District Public Schools
   a. For district public school Applicants using a district’s voted general obligation bond authorization for a Guaranteed Financing, property tax collections for the three most recent fiscal years must average 90% or more.
   b. For district public school Applicants that will not use the property tax base for a Guaranteed Financing, the Applicant must identify the authorized source of payment for the Guaranteed Financing and provide evidence of adequate ongoing dedicated or pledged revenues and budget capacity to service the minimum annual payments to be due under the Guaranteed Financing and any other parity obligations at 110% of the annual payments due.

5. Guaranteed Financings Secured by Real Property
   a. If the Guaranteed Financing will involve property or facilities that will be pledged as collateral for the Guaranteed Financing, the Applicant must provide an independent appraisal to the Board dated not less than 30 calendar days and not more than 60 calendar days before the issuance of the Guaranteed Financing indicating that the “as built” value of the pledged property is equal to or greater than the principal amount of the Guaranteed Financing, net of reserves securing the Guaranteed Financing and transaction costs for the Guaranteed Financing. At the time of Application, the Applicant shall certify that it reasonably believes this requirement will be met at the time of the Guaranteed Financing. For Guaranteed Financings that will refinance prior existing debt obligations of the Applicant, the Applicant may grant a security interest in the pledged property to secure debt obligations under the related financing that are not guaranteed by the Fund, provided that such security interest is subordinate to the security interest granted by the Applicant in such pledged property to secure the Guaranteed Financing.
   b. The Applicant must identify or describe the ownership status of the property/facilities that will be funded by the Guaranteed Financing, including whether the property will be owned in fee simple, will be leased, or will be subject to some other control or ownership agreement.
   c. For property being leased, the Applicant must provide a copy of the lease and identify the term, renewal options, assignment rights and the payment schedule.
   d. For a Guaranteed Financing that will require construction of new facilities or major renovations to existing facilities of $1,000,000.00 or more, the Applicant must acknowledge that the Guaranteed Financing is contingent upon execution of a guaranteed maximum price contract or other acceptable
mechanism ensuring project completion, along with a requirement for the contractor to provide a completion bond or its equivalent.

6. Refinancing Guaranteed Financings – for Guaranteed Financings that will refinance a prior existing debt obligation for which the originally pledged property will be pledged as collateral for the Guaranteed Financing, payments on the Guaranteed Financing may not be greater in any fiscal year than the scheduled payments on the prior obligations, and the savings to be generated on a present value basis must equal or exceed 5% of the principal amount of the refinanced obligations.

I. Arizona Public School Credit Enhancement – Evaluation of Applications

1. Applications shall be reviewed to confirm that all required information has been received and the Application is administratively complete. Within 30 days of submission of an Application, the Applicant will be notified of any deficiencies in the Application.

2. Once an Application is determined to be administratively complete, the Board shall evaluate each Application and either approve or deny the Application within 60 days of this determination.

3. In deciding whether to approve or deny an Application, the Board may give preference to:
   a. Proposed Guaranteed Financings that fund projects in low socioeconomic areas or to serve low socioeconomic student populations;
   b. Proposed Guaranteed Financings based on the geographic distribution of Guaranteed Financings throughout the state;
   c. Proposed Guaranteed Financings that fund new classrooms or facilities to meet established enrollment demand; and
   d. Proposed Guaranteed Financings that will maintain the overall program requirements imposed by A.R.S. § 15-2155(C).

4. The Board shall meet no less than once every other month to decide upon Applications and for the conduct of any and all other business before the Board. The Board is authorized to call additional meetings in order to evaluate Applications or conduct other business and to cancel meetings if there is no business pending before the Board.

5. Applicants shall be notified of the Board’s decision to grant or deny credit enhancement to a proposed Guaranteed Financing within 10 business days of the Board’s decision in writing, either by letter, facsimile or electronic mail.

J. Deadline for Issuance of Guaranteed Financing – Once the Applicant is awarded initial approval for a Guaranteed Financing, the Applicant must issue the Guaranteed Financing within 120 days of the date of the letter granting approval for the Guaranteed Financing. The initial approval for the Guaranteed Financing will expire at the end of the 120-day period. The Applicant may request an extension for an additional 60 days by submitting a written request to the Board setting forth the reasons for the requested extension, before the expiration of the initial 120-day period.

K. Arizona Public School Credit Enhancement Participation Fee – In setting participation fees pursuant to A.R.S. § 15-2155(E), the Board shall consider, among other things, the value and type of collateral being pledged, the term of the Guaranteed Financing, projected savings by the School through the Guaranteed Financing, the rating of the proposed Guaranteed Financing without regard to the credit enhancement to be provided, the overall amount of the Guaranteed Financing and whether the Achievement District School is a district public school or a charter public school. The Board may establish the participation fee as a percentage of the Guaranteed Financing or otherwise, depending on the specific terms of the Guaranteed Financing.

Historical Note
New Section made by final exempt rulemaking at 23 A.A.R. 661, effective March 1, 2017 (Supp. 17-1).
41-5853. Powers and duties of the board

A. The board is a body corporate and politic and may have an official seal that is judicially noticed.

B. The board may:

1. Sue and be sued in its own name.

2. Contract and enter into agreements as necessary to carry out its responsibilities under this article.

3. Contract with experts, advisers, consultants and agents, including financial experts, legal counsel and other advisers and consultants as may be necessary for services to assist the board.

4. Make and execute contracts and other instruments necessary or convenient for the performance of its duties and the exercise of its power and functions.

5. Pursuant to section 41-5855, approve financing for an achievement district school as guaranteed financing under the program.

6. Do all acts, whether or not expressly authorized, that may be deemed necessary or proper for the protection of the monies in the Arizona public school credit enhancement fund, except that the board may not take any action that would create a general or moral obligation of this state or any agency of the state.

7. Contract with any entity relating to guaranteed financings.

8. Issue program funding obligations pursuant to section 41-5857.

9. Adopt rules governing the operation of the program.

10. Take any other action that is necessary or appropriate to carry out this article.

C. The division shall provide staff as requested by the board to support the activities of the board.
BOARD OF PSYCHOLOGIST EXAMINERS
Title 4, Chapter 26, Article 1 & 4
Summary

This One-Year Review Report (1YRR) from the Board of Psychologist Examiners (Board) relates to rules in Title 4, Chapter 26 regarding fees for out-of-state health providers of psychologists and behavior analyst services to register to provide telehealth services in Arizona. These rules establish the fees the Board charges for the licenses, certificates, and registrations it issues to psychologists and behavior analysts, and sets forth the licensing time frames.

The Board submitted this 1YRR pursuant to A.R.S. § 41-1095.

1. Has the agency analyzed whether the rules are authorized by statute?

   Yes, the Board cites both general and specific statutory authority for the rules.

2. Summary of the agency’s economic impact comparison and identification of stakeholders:

   Because Laws 2021, Chapter 320, Sec. 24, exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement when the rulemaking was done. In the 10 months since the rules went into
effect, the Board has received no applications from psychologists to register as an out-of-state provider of telehealth and no applications from behavior analysts to register as an out-of-state provider of telehealth. Because the Board received no applications to register, no fees were received and there was nothing to deposit in the state’s general fund or the Board of Psychologist Examiners Fund (See A.R.S. § 32-2065).

The Board believes no out-of-state providers have registered because they continue to rely on a temporary emergency license under A.R.S. § 32-3124 or a temporary waiver of licensure requirements during a state of emergency under A.R.S. § 36-787(A)(7). Neither of these provisions requires a fee. The authority for the temporary emergency license terminates on January 1, 2023. At that time, the Board expects most out-of-state psychologists will use the interstate compact PSYPACT to practice in Arizona rather than register under A.R.S. § 36-3606. Behavior analysts may register under A.R.S. § 36-3606 when the authority for a temporary emergency license terminates.

3. **Has the agency analyzed the costs and benefits of the rulemaking and determined that the rules impose the least burden and costs to those who are regulated?**

When the legislature enacted A.R.S. § 36-3606, the legislature determined the benefits from allowing registration of out-of-state providers of psychological or behavior analysis services by telehealth outweighs the costs to the state. The legislature established the paperwork cost when it specified the content of an application that must be submitted and established multiple compliance requirements at A.R.S. § 36-3606(A)(2) through (A)(9), (B), and (C). In establishing these paperwork and compliance requirements, the legislature determined the requirements imposed the least burden and costs on out-of-state providers of psychological or behavior analysis services by telehealth necessary to achieve the underlying regulatory objective.

The rules reviewed for this report comply with the minimal authority the legislature provided to the Board: R4-26-108(B) and R4-26-402(B) establish the fees the Board charges for an out-of-state health care provider to register to provide telehealth services in Arizona. In establishing the fee amount, the Board assumed registered out-of-state providers would maintain their telehealth registrations because the only cost to the out-of-state providers is to submit a renewal registration form. The Board is required to supervise compliance of the out-of-state providers and process the annual registration forms without authority to charge a renewal fee. Because this is the only authority provided to the Board and because the legislature determined there is benefit in allowing out-of-state providers of services by telehealth to register to provide the services in Arizona, the Board concludes the benefits of the rule outweigh the costs.

4. **Has the agency received any written criticisms of the rules since the rule was adopted?**

No, the Board indicates they have not received any written criticisms of the rules since the rules were adopted.
5. **Has the agency analyzed the rules’ clarity, conciseness, and understandability?**

Yes, the Board indicates the rules are clear, concise, and understandable.

6. **Has the agency analyzed the rules’ consistency with other rules and statutes?**

Yes, the Board indicates the rules are consistent with other rules and statutes.

7. **Has the agency analyzed the rules’ effectiveness in achieving its objectives?**

Yes, the Board indicates the rules are effective in achieving its objectives.

8. **Has the agency analyzed the current enforcement status of the rules?**

Yes, the Board indicates the rules are enforced as written.

9. **Are the rules more stringent than corresponding federal law and, if so, is there statutory authority to exceed the requirements of federal law?**

No, the Board indicates the rules are not more stringent than corresponding federal law.

10. **Has the agency completed any additional process required by law?**

Not applicable.

11. **Do the rules require a permit or license and, if so, does the agency comply with A.R.S. § 41-1037?**

No, the Board indicates the rules do not require a permit or license.

12. **Conclusion**

This 1YRR from the Board relates to rules in Title 4, Chapter 26 regarding fees for out-of-state health providers of psychologists and behavior analyst services to register to provide telehealth services in Arizona. These rules establish the fees the Board charges for the licenses, certificates, and registrations it issues to psychologists and behavior analysts, and sets forth the licensing time frames.

Council staff finds that the Board submitted an adequate report pursuant to A.R.S. § 41-1095. Council staff recommends approval of this report.
July 5, 2022

VIA EMAIL: grrc@azdoa.gov
Nicole Sornsin, Chair
Governor’s Regulatory Review Council
100 North 15th Avenue, Suite 305
Phoenix, Arizona 85007

RE: Board of Psychologist Examiners
One-year-review Report
R4-26-108, Table 1, R4-26-402, and R4-26-417

Dear Ms Sornsin:

The referenced report, which is required under A.R.S. § 41-1095(A) and due by September 1, 2022, is submitted for the Council’s review and approval.

The Board complies with A.R.S. § 41-1091.

For questions about this report, please contact Heidi Herbst Paakkonen at 602-542-3018 or heidi.paakkonen@psychboard.az.gov.

Sincerely,

Heidi Herbst Paakkonen
Executive Director
INTRODUCTION

The legislature enacted Laws 2021, Chapter 320, as an emergency measure to expand use of telehealth in meeting the health-care needs of Arizonans. The statute (A.R.S. § 36-3606) included a provision allowing a health care provider not licensed in this state to provide telehealth services to individuals in Arizona if the out-of-state health care provider registered with Arizona’s applicable regulatory board and paid a fee specified by the regulatory board. The Board established the fee for both out-of-state health care providers of psychologist and behavior analyst services to register to provide telehealth services in Arizona in a rulemaking that went into effect on September 1, 2021. The Board also amended the Board’s time frame table and R4-26-417 to include the new registrations.

As required under A.R.S. § 41-1095(A), this report focuses on the Board’s review of R4-26-108, Table 1, R4-26-402, and R4-26-417, the four provisions amended under the exemption provided by Laws 2021, Chapter 320, Sec. 24.

Statute that generally authorizes the agency to make rules: A.R.S. § 32-2063(A)(9) and (12)

1. Specific statute authorizing the rules: A.R.S. §§ 36-3606(A)(3) and 41-1073

2. Objective of the rules:
   R4-26-108. Fees and Charges: The objective of this rule is to establish the fees the Board charges for the licenses, certificates, and registrations it issues to psychologists and the charges made for services.

   Table 1. Time Frames (in days) for Processing Applications: The objective of this rule is to provide notice of the amount of time the Board requires to act of an application from a psychologist.

   R4-26-402. Fees and Charges: The objective of this rule is to establish the fees the Board charges for the licenses and registrations it issues to behavior analysts and the charges made for services.
R4-26-417. Licensing Time Frames: The objective of this rule is to provide notice of the amount of time the Board requires to act on an application from a behavior analyst.

3. Are the rules effective in achieving its objective? Yes

4. Were there written criticisms of the rules, including written analyses questioning whether the rules are based on valid scientific or reliable principles or methods? No

5. Are the rules consistent with other rules and statutes? Yes

6. Are the rules enforced as written? Yes

7. Are the rules clear, concise, and understandable? Yes

8. Estimated economic, small business, and consumer impact of the rule:
   Because Laws 2021, Chapter 320, Sec. 24, exempted the Board from complying with A.R.S. Title 41, Chapter 6, the Board did not prepare an economic, small business, and consumer impact statement when the rulemaking was done. In the 10 months since the rules went into effect, the Board has received no applications from psychologists to register as an out-of-state provider of telehealth and no applications from behavior analysts to register as an out-of-state provider of telehealth. Because the Board received no applications to register, no fees were received and there was nothing to deposit in the state’s general fund or the Board of Psychologist Examiners Fund (See A.R.S. § 32-2065).

   The Board believes no out-of-state providers have registered because they continue to rely on a temporary emergency license under A.R.S. § 32-3124 or a temporary waiver of licensure requirements during a state of emergency under A.R.S. § 36-787(A)(7). Neither of these provisions requires a fee. The authority for the temporary emergency license terminates on January 1, 2023. At that time, the Board expects most out-of-state psychologists will use the interstate compact PSYPACT to practice in Arizona rather than register under A.R.S. § 36-3606. Behavior analysts may register under A.R.S. § 36-3606 when the authority for a temporary emergency license terminates.

9. Has the agency received any business competitiveness analyses of the rule? No

10. If applicable, whether the agency completed additional processes required by law: NA
A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

When the legislature enacted A.R.S. § 36-3606, the legislature determined the benefits from allowing registration of out-of-state providers of psychological or behavior analysis services by telehealth outweighs the costs to the state. The legislature established the paperwork cost when it specified the content of an application that must be submitted and established multiple compliance requirements at A.R.S. § 36-3606(A)(2) through (A)(9), (B), and (C). In establishing these paperwork and compliance requirements, the legislature determined the requirements imposed the least burden and costs on out-of-state providers of psychological or behavior analysis services by telehealth necessary to achieve the underlying regulatory objective.

The only authority provided to the Board under A.R.S. § 36-3606 is to establish a one-time-only registration fee. The fee is the only compliance cost established by the Board in the reviewed rules. For this one-time fee, the Board is required to evaluate the application information submitted by the out-of-state provider, supervise compliance for as long as the out-of-state provider may choose to provide telehealth services to residents of Arizona, and receive and evaluate an annual update from the out-of-state provider. The legislature did not authorize the Board to establish a fee for the annual renewal of the registration by an out-of-state provider of telehealth services.

The rules reviewed for this report comply with the minimal authority the legislature provided to the Board: R4-26-108(B) and R4-26-402(B) establish the fees the Board charges for an out-of-state health care provider to register to provide telehealth services in Arizona. In establishing the fee amount, the Board assumed registered out-of-state providers would maintain their telehealth registrations because the only cost to the out-of-state providers is to submit a renewal registration form. The Board is required to supervise compliance of the out-of-state providers and process the annual registration forms without authority to charge a renewal fee. Because this is the only authority provided to the Board and because the legislature determined there is benefit in allowing out-of-state providers of services by telehealth to register to provide the services in Arizona, the Board concludes the benefits of the rule outweigh the costs.
The time frames listed in Table 1 and R4-26-417 run against the Board. The time frames do not regulate out-of-state health care providers.

12. Is the rule more stringent than corresponding federal laws?  
No

13. For a rule that requires issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:
   
   None of the rules requires issuance of a permit, license, or other authorization. The requirements for registration are established in statute. The rules simply specify the fee required.
August 5, 2022

Ms. Nicole Sornsin, Chair
The Governor’s Regulatory Review Council
100 North 15th Avenue, Ste. 305
Phoenix, AZ 85007

Re: One Year Rule Review of A.A.C. Title 4. Professions and Occupations; Chapter 26. Board of Psychologist Examiners; Articles 1 and 4

Dear Ms. Sornsin:

On behalf of the Arizona Board of Psychologist Examiners (“Board”) I am supplying you with an explanation of the fee at which the Board arrived for applications to the Telehealth Registry. Pursuant to A.R.S. § 36-3606(A)(3), the Board established a $600 registration fee during its June 4, 2021 meeting.

The Board considered the following while deliberating the registration fee:

• The enabling legislation does not permit the Board to charge a fee for processing the required annual renewal of a Telehealth Registration. This means a one-time fee must cover the entire cost of regulating Registrants to include processing the initial registration, processing every annual registration update, and conducting any investigations for the entire duration of the Registration.

• Accordingly, the Board had to make some assumptions relative to the duration of time that Registrants would submit active registrations. The attached accounting reflects that $600 barely covers the cost of a Registration that is active for 8 years (assuming costs stay fixed, and the Registrant is not the subject of an investigation).

• The application intake system development was completed gratis by the Arizona Strategic Enterprise Technology (ASET). This in-kind donation helped reduce the application processing cost.

• If in the future the Arizona State Legislature grants to the Board the authority to charge an annual update fee, it will revisit the need to charge a $600 registration fee.

A.R.S. § 36-3606 grants to an interstate telehealth provider the same telehealth privileges as an Arizona licensed psychologist and behavior analyst. By way of comparison; a licensed psychologist, and a licensed behavior analyst, will pay $2,350 in fees to the Board for the same practice privileges for the same 8-year period of time.

I will participate in the August 30, 2022 study session of the Council to answer questions and provide any additional clarification requested.

 Regards,

Heidi Herbst Paakkonen, MPA
Executive Director
<table>
<thead>
<tr>
<th>Staff Hourly Rate (Inclusive of Employee Related Expenses)</th>
<th>Hours to Process/Review Initial Application*</th>
<th>Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$41.00</td>
<td>2</td>
<td></td>
<td>$82.00</td>
</tr>
<tr>
<td>$41.00</td>
<td>4</td>
<td></td>
<td>$164.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hourly Rate - 10 Board Members</th>
<th>Hours to Process/Review Application</th>
<th>Hours to Process Annual Update (assumes 0.5 hour each year for 8 years)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$140.00</td>
<td>0.5</td>
<td></td>
<td>$280.00</td>
</tr>
</tbody>
</table>

Cost to Maintain Record in Database (Assumes 20 Years) **

$0.29 x 12 months x 20 years

$70

$596.00

The fee assumes there are to be no investigative costs incurred.

* Includes responding to applicant inquiries; downloading submitted documents; issuing a notice of application deficiency; issuing a notice of administrative completedness; issuing a notice of approval; adding name to the application review committee agenda and the file to the meeting folder; adding name to the Board meeting agenda and adding the file to the meeting review folder.

** The Board’s cloud-based management system charges a subscription fee based on a per-record formula. This applies to both active and inactive records.
R4-26-108. Fees and Charges
A. As specifically authorized by A.R.S. § 32-2067(A), the Board establishes and shall collect the following fees:
   1. Application for an active license to practice psychology: $350;
   2. Application for a temporary license under A.R.S. § 32-2073(B): $200
   3. Reapplication for an active license: $200;
   4. Issuance of an initial active or temporary license (prorated, as applicable): $500;
   5. Duplicate license: $25;
   6. Biennial renewal of an active license: $500;
   7. Biennial renewal of an inactive license: $85;
   8. Reinstatement of an active or inactive license: $200; and
B. Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: $600.
C. As specifically authorized by A.R.S. § 32-2067(A), the Board establishes and shall collect the following charges for the services provided:
   1. Duplicate renewal receipt: $5;
   2. Copy of statutes and rules: $5;
   3. Verification of a license: $2;
   4. Audio recording of a Board or Committee meeting: $10;
   5. Electronic medium containing the name and address of each licensee: $.05 per name;
   6. Customized electronic medium containing the name and address of each current licensee: $.25 per name;
   7. Customized electronic medium containing additional, non-confidential, licensee information: $.35 per name; and
   8. Copies of Board records, documents, letters, minutes, applications, files, and policy statements: $.25 per page.
D. Except as provided by law, including A.R.S. § 41-1077, the fees listed in subsections (A) and (B) are not refundable.

Table 1. Time Frames (in days) for Processing Applications

<table>
<thead>
<tr>
<th>Type of Application or Request</th>
<th>Statutory or Rule Authority</th>
<th>Administrative Completeness Time Frame</th>
<th>Time to Respond to Notice of Deficiency</th>
<th>Substantive Review Time Frame</th>
<th>Time to Respond to Request for Additional Information</th>
<th>Overall Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application for initial license</td>
<td>A.R.S. §§ 32-2071, 32-2071.01, 32-2072, and R4-26-203</td>
<td>30</td>
<td>240</td>
<td>90</td>
<td>365</td>
<td>120</td>
</tr>
<tr>
<td>Application for licensure by credential</td>
<td>A.R.S. §§ 32-2071.01, 32-2072; and R4-26-203.01</td>
<td>30</td>
<td>240</td>
<td>90</td>
<td>240</td>
<td>120</td>
</tr>
<tr>
<td>Application to Take National Examination before Completing Experience Required for Licensure</td>
<td>A.R.S. § 32-2072(C) and R4-26-203.02</td>
<td>30</td>
<td>240</td>
<td>90</td>
<td>240</td>
<td>120</td>
</tr>
<tr>
<td>Reapplication for Licensure</td>
<td>A.R.S. § 32-2067 and R4-26-203.03</td>
<td>30</td>
<td>240</td>
<td>90</td>
<td>240</td>
<td>120</td>
</tr>
<tr>
<td>Application for license renewal</td>
<td>A.R.S. § 32-2074; R4-26-205</td>
<td>60</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
<td>150</td>
</tr>
<tr>
<td>Application for reinstatement of expired license</td>
<td>A.R.S. § 32-2074; R4-26-206</td>
<td>60</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
<td>150</td>
</tr>
<tr>
<td>Request for extension of time to complete continuing education</td>
<td>A.R.S. § 32-2074; R4-26-207</td>
<td>60</td>
<td>N/A</td>
<td>90</td>
<td>N/A</td>
<td>150</td>
</tr>
<tr>
<td>Application for registration as an out-of-state health care provider of telehealth services</td>
<td>A.R.S. § 36-3606; R4-26-108</td>
<td>30</td>
<td>240</td>
<td>90</td>
<td>365</td>
<td>120</td>
</tr>
</tbody>
</table>

**R4-26-402. Fees and Charges**

A. As specifically authorized by A.R.S. §§ 32-2091.01(A) and 32-2091.07(B), the Board establishes and shall collect the following fees:
1. Application for an active license: $350;
2. Renewal of an active license: $500;
3. Renewal of an inactive license: $85;
4. Issuance of an initial license: $500; and

B. Under the specific authority provided by A.R.S. § 36-3606(A)(3), the Board establishes and shall collect the following fee to register as an out-of-state health care provider of telehealth services: $600.

C. As specifically authorized by A.R.S. § 32-2091.01(B), the Board establishes and shall collect the following charges for the services specified:
1. Duplicate license: $25;
2. Duplicate renewal receipt: $5;
3. Copy of the Board’s statutes and rules: $5;
4. Verification of a license: $2;
5. Audio recording of a Board meeting: $10 per meeting;
6. Electronic medium containing the name and address of all licensees: $.05 per name;
7. Customized electronic medium containing the name and address of all licensees: $.25 per name;
8. Customized electronic medium: $.35 per name; and
9. Copy of Board records, letters, minutes, applications, files, policy statements, and other non-confidential documents: $.25 per page.

D. Except as provided by law, including A.R.S. § 41-1077, the fees listed in subsections (A) and (B) are not refundable.

R4-26-417. Licensing Time Frames
A. For the purpose of A.R.S. § 41-1073, the Board establishes the following time frames:
   1. Initial license.
      a. Overall time frame: 120 days,
      b. Administrative completeness review time frame: 30 days, and
      c. Substantive review time frame: 90 days;
   2. Renewal license.
      a. Overall time frame: 150 days,
      b. Administrative completeness review time frame: 60 days, and
      c. Substantive review time frame: 90 days; and
   3. Initial registration as an out-of-state health care provider of telehealth services.
      a. Overall time frame: 120 days,
      b. Administrative completeness review time frame: 30 days, and
      c. Substantive review time frame: 90 days.
B. An applicant and the Executive Director of the Board may agree in writing to extend the substantive review and overall time frames by no more than 25 percent of the overall time frame.
C. The administrative completeness review time frame begins when the Board receives the application materials required under R4-26-403, R4-26-408(C) and (D), or as prescribed under A.R.S. § 36-3606. During the administrative completeness review time frame, the Board shall notify the applicant that the application is either complete or incomplete. If the application is incomplete, the Board shall specify in the notice what information is missing.
D. An applicant whose application is incomplete shall submit the missing information to the Board within 240 days for an initial license. Both the administrative completeness review and overall time frames are suspended from the date of the Board’s notice under subsection (C) until the Board receives all of the missing information.
E. Upon receipt of all missing information, the Board shall notify the applicant that the application is complete. The Board shall not send a separate notice of completeness if the Board grants or denies a license within the administrative completeness review time frame listed in subsection (A)(1)(b) or (A)(2)(b).
F. The substantive review time frame begins on the date of the Board’s notice of administrative completeness.
G. If the Board determines during the substantive review that additional information is needed, the Board shall send the applicant a comprehensive written request for additional information.
H. An applicant who receives a request under subsection (G) shall submit the additional information to the Board within 240 days. Both the substantive review and overall time frames are suspended from the date of the Board’s request until the Board receives the additional information.
I. An applicant may receive a 30-day extension of the time provided under subsection (D) or (H) by providing written notice to the Board before the time expires. If an applicant fails to submit to the Board the missing or additional information within the time provided under subsection (D) or (H) or the time as extended, the Board shall close the applicant’s file. To receive further consideration, a person whose file is closed shall re-apply.

J. Within the overall time frame listed in subsection (A), the Board shall:
1. Grant a license if the Board determines that the applicant meets all criteria required by statute and this Article; or
2. Deny a license if the Board determines that the applicant does not meet all criteria required by statute and this Article.

K. If the Board grants a license under subsection (J)(1), the Board shall send the applicant a notice explaining that the Board shall issue the license only after the applicant pays the license issuance fee specified under R4-26-402 and pro-rated as prescribed under A.R.S. § 32-2091.07(A).

L. If the Board denies a license, the Board shall send the applicant a written notice explaining:
1. The reason for denial, with citations to supporting statutes or rules;
2. The applicant’s right to appeal the denial by filing an appeal under A.R.S. Title 41, Chapter 6, Article 10;
3. The time for appealing the denial; and
4. The applicant’s right to request an informal settlement conference.

M. If a time frame’s last day falls on a Saturday, Sunday, or official state holiday, the next business day is the time frame’s last day.
Powers and duties

A. The board shall:

1. Administer and enforce this chapter and board rules.

2. Regulate disciplinary actions, the granting, denial, revocation, renewal and suspension of licenses and the rehabilitation of licensees pursuant to this chapter and board rules.

3. Prescribe the forms, content and manner of application for licensure and renewal of licensure and set deadlines for the receipt of materials required by the board.

4. Keep a record of all licensees, board actions taken on all applicants and licensees and the receipt and disbursal of monies.

5. Adopt an official seal for attesting licenses and other official papers and documents.

6. Investigate charges of violations of this chapter and board rules and orders.

7. Subject to title 41, chapter 4, article 4, employ an executive director who serves at the pleasure of the board.

8. Annually elect from among its membership a chairman, a vice chairman and a secretary, who serve at the pleasure of the board.

9. Adopt rules pursuant to title 41, chapter 6 to carry out this chapter and to define unprofessional conduct.

10. Engage in a full exchange of information with other regulatory boards and psychological associations, national psychology organizations and the Arizona psychological association and its components.

11. By rule, adopt a code of ethics relating to the practice of psychology. The board shall base this code on the code of ethics adopted and published by the American psychological association. The board shall apply the code to all board enforcement policies and disciplinary case evaluations and development of licensing examinations.

12. Adopt rules regarding the use of telepractice.

13. Before the board takes action, receive and consider recommendations from the committee on behavior analysts on all matters relating to licensing and regulating behavior analysts, as well as regulatory changes pertaining to the practice of behavior analysis, except in the case of a summary suspension of a license pursuant to section 32-2091.09, subsection E.

14. Beginning January 1, 2022, require each applicant for an initial or temporary license or a license renewal pursuant to this chapter to have applied for a fingerprint clearance card pursuant to title 41, chapter 12, article 3.1. If an applicant is issued a valid fingerprint clearance card, the applicant shall submit the valid fingerprint clearance card to the board with the completed application. If an applicant applies for a fingerprint clearance card and is denied, the applicant may request that the board consider the application for licensure notwithstanding the absence of a valid fingerprint clearance card. The board, in its discretion, may approve an application for licensure despite the denial of a valid fingerprint clearance card if the board determines that the applicant's criminal history information on which the denial is based does not alone disqualify the applicant from licensure.
B. Subject to title 41, chapter 4, article 4, the board may employ personnel it deems necessary to carry out this chapter. The board, in investigating violations of this chapter, may employ investigators who may be psychologists. The board or its executive director may take and hear evidence, administer oaths and affirmations and compel by subpoena the attendance of witnesses and the production of books, papers, records, documents and other information relating to the investigation or hearing.

C. Subject to section 35-149, the board may accept, expend and account for gifts, grants, devises and other contributions, monies or property from any public or private source, including the federal government. The board shall deposit, pursuant to sections 35-146 and 35-147, monies received pursuant to this subsection in special funds for the purpose specified, and monies in these funds are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

D. Compensation for all personnel shall be determined pursuant to section 38-611.

36-3606. Interstate telehealth services; registration; requirements; venue; exceptions

A. A health care provider who is not licensed in this state may provide telehealth services to a person located in this state if the health care provider complies with all of the following:

1. Registers with this state's applicable health care provider regulatory board or agency that licenses comparable health care providers in this state on an application prescribed by the board or agency that contains all of the following:
   (a) The health care provider's name.
   (b) Proof of the health care provider's professional licensure, including all United States jurisdictions in which the provider is licensed and the license numbers. Verification of licensure in another state shall be made through information obtained from the applicable regulatory board's website.
   (c) The health care provider's address, email address and telephone number, including information if the provider needs to be contacted urgently.
   (d) Evidence of professional liability insurance coverage.
   (e) Designation of a duly appointed statutory agent for service of process in this state.

2. Before prescribing a controlled substance to a patient in this state, registers with the controlled substances prescription monitoring program established pursuant to chapter 28 of this title.

3. Pays the registration fee as determined by the applicable health care provider regulatory board or agency.

4. Holds a current, valid and unrestricted license to practice in another state that is substantially similar to a license issued in this state to a comparable health care provider and is not subject to any past or pending disciplinary proceedings in any jurisdiction. The health care provider shall notify the applicable health care provider regulatory board or agency within five days after any restriction is placed on the health care provider's license or any disciplinary action is initiated or imposed. The health care provider regulatory board or agency registering the health care provider may use the national practitioner databank to verify the information submitted pursuant to this paragraph.

5. Acts in full compliance with all applicable laws and rules of this state, including scope of practice, laws and rules governing prescribing, dispensing and administering prescription drugs and devices, telehealth
requirements and the best practice guidelines adopted by the telehealth advisory committee on telehealth best practices established by section 36-3607.

6. Complies with all existing requirements of this state and any other state in which the health care provider is licensed regarding maintaining professional liability insurance, including coverage for telehealth services provided in this state.

7. Consents to this state's jurisdiction for any disciplinary action or legal proceeding related to the health care provider's acts or omissions under this article.

8. Follows this state's standards of care for that particular licensed health profession.

9. Annually updates the health care provider's registration for accuracy and submits to the applicable health care provider regulatory board or agency a report with the number of patients the provider served in this state and the total number and type of encounters in this state for the preceding year.

B. A health care provider who is registered pursuant to this section may not:

1. Open an office in this state, except as part of a multistate provider group that includes at least one health care provider who is licensed in this state through the applicable health care provider regulatory board or agency.

2. Provide in-person health care services to persons located in this state without first obtaining a license through the applicable health care provider regulatory board or agency.

C. A health care provider who fails to comply with the applicable laws and rules of this state is subject to investigation and both nondisciplinary and disciplinary action by the applicable health care provider regulatory board or agency in this state. For the purposes of disciplinary action by the applicable health care provider regulatory board or agency in this state, all statutory authority regarding investigating, rehabilitating and educating health care providers may be used. If a health care provider fails to comply with the applicable laws and rules of this state, the applicable health care provider regulatory board or agency in this state may revoke or prohibit the health care provider's privileges in this state, report the action to the national practitioner database and refer the matter to the licensing authority in the state or states where the health care provider possesses a professional license. In any matter or proceeding arising from such a referral, the applicable health care provider regulatory board or agency in this state may share any related disciplinary and investigative information in its possession with another state licensing board.

D. The venue for any civil or criminal action arising from a violation of this section is the patient's county of residence in this state.

E. A health care provider who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another jurisdiction and who provides telehealth services to a person located in this state is not subject to the registration requirements of this section if either of the following applies:

1. The services are provided under one of the following circumstances:

(a) In response to an emergency medication condition.

(b) In consultation with a health care provider who is licensed in this state and who has the ultimate authority over the patient's diagnosis and treatment.

(c) To provide after-care specifically related to a medical procedure that was delivered in person in another state.
(d) To a person who is a resident of another state and the telehealth provider is the primary care provider or behavioral health provider located in the person's state of residence.

2. The health care provider provides fewer than ten telehealth encounters in a calendar year.

41-1073. **Time frames; exception**

A. No later than December 31, 1998, an agency that issues licenses shall have in place final rules establishing an overall time frame during which the agency will either grant or deny each type of license that it issues. Agencies shall submit their overall time frame rules to the governor's regulatory review council pursuant to the schedule developed by the council. The council shall schedule each agency's rules so that final overall time frame rules are in place no later than December 31, 1998. The rule regarding the overall time frame for each type of license shall state separately the administrative completeness review time frame and the substantive review time frame.

B. If a statutory licensing time frame already exists for an agency but the statutory time frame does not specify separate time frames for the administrative completeness review and the substantive review, by rule the agency shall establish separate time frames for the administrative completeness review and the substantive review, which together shall not exceed the statutory overall time frame. An agency may establish different time frames for initial licenses, renewal licenses and revisions to existing licenses.

C. The submission by the department of environmental quality of a revised permit to the United States environmental protection agency in response to an objection by that agency shall be given the same effect as a notice granting or denying a permit application for licensing time frame purposes. For the purposes of this subsection, "permit" means a permit required by title 49, chapter 2, article 3.1 or section 49-426.

D. In establishing time frames, agencies shall consider all of the following:

1. The complexity of the licensing subject matter.
2. The resources of the agency granting or denying the license.
3. The economic impact of delay on the regulated community.
4. The impact of the licensing decision on public health and safety.
5. The possible use of volunteers with expertise in the subject matter area.
6. The possible increased use of general licenses for similar types of licensed businesses or facilities.
7. The possible increased cooperation between the agency and the regulated community.
8. Increased agency flexibility in structuring the licensing process and personnel.

E. This article does not apply to licenses issued either:

1. Pursuant to tribal state gaming compacts.
2. Within seven days after receipt of initial application.
3. By a lottery method.
CONSIDERATION AND DISCUSSION OF 2023 COUNCIL CALENDAR
## GOVERNOR’S REGULATORY REVIEW COUNCIL DEADLINES FOR 2023 (MEETING DATES ARE SUBJECT TO CHANGE)

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<tr>
<th>DEADLINE FOR PLACEMENT ON AGENDA*</th>
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* 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.